Medical Economics

NOVEMBER

FOUR DECADES OF HORSE-AND-BUGGY HOUSE CALLS • PAR

Amino-Concemin

a **synergistic** combination of
B Complex, Iron and **Amino Acids**

Specifically designed to shorten convalescence, through the catalytic action of amino acids on vitamin assimilation and iron utilization.[1, 2] Provides nutritional elements often deficient in the usual convalescent diet:

1. B COMPLEX—the established B vitamins, in high potencies, plus the entire B complex from three natural sources.
2. IRON—to counteract the frequently associated hypochromic anemia.
3. AMINO ACIDS—a 15% enzymatic yeast hydrolysate containing 10 essential amino acids with other amino acids and polypeptides, provides *extra* nitrogen as well as a synergistic effect on hemoglobin formation and vitamin utilization.

FORMULA

Each 45 cc. (average daily dose) contains:

Protein hydrolysate (45% amino acids)	6.75 Gm.
Thiamine hydrochloride	3.0 mg.
Riboflavin	2.0 mg.
Niacinamide	15.0 mg.
Pyridoxine hydrochloride	1.0 mg.
Peptonized iron, U.S.P.	0.4 Gm.
Liver, B complex fraction	0.5 Gm.
Rice bran extract	0.5 Gm.

Rich winey flavor

The delightful winey flavor of Amino-Concemin—unusual in a product containing amino acids, liver and iron—assures continued patient cooperation. Many find it particularly pleasant in milk or fruit juice. Dosage—15 cc. (1 tablespoon) three times a day, with or before meals.

1. Jacobson, M.: N. Y. State J. Med. *45*:2079-2080 (1945).
2. Ruskin, S. L.: Am. J. Dig. Dis.: *13*:110-122 (1946).

AVAILABLE AT HOSPITAL AND PRESCRIPTION PHARMACIES IN PINTS AND GALLONS

Trademark "Amino-Concemin" Reg. U. S. Pat. Off.

Wm. S. Merrell Company, Cincinnati, U. S. A.

MERRELL 1828

Medical Economics

NOVEMBER 1947

H. Sheridan Baketel, M.D., Editor-in-Chief. William Alan Richardson, Editor. Edmund R. Beckwith, Jr. and R. Cragin Lewis, Associate Editors. Lansing Chapman, Publisher. W. L. Chapman, Jr., Business Manager. R. M. Smith, Sales Manager.

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ANGINA PECTORIS

and other Manifestations of CORONARY INSUFFICIENCY

The following episodes may be prevented by appropriately regulated administration of a vasodilator having a sustained effect:

FOR THE PERSON

- *who is compelled to stop and rest when climbing a flight of stairs.*
- *who suffers "indigestion" and "gas" on exertion, or after a heavy meal.*
- *who is stricken with precordial pain on unusual exertion or emotion, or when exposed to cold.*

The vasodilatation produced by Erythrol Tetranitrate Merck begins 15 to 20 minutes after administration, and lasts from 3 to 4 hours.

It is generally agreed that the acute attack of anginal pain is most readily relieved by the prompt removal of the provocative factor, and by the use of nitrites. For prophylactic purposes—to control anticipated paroxysms—the delayed but prolonged action *of erythrol tetranitrate is effective. Erythrol tetranitrate, because of its slower* and more prolonged *action, is also considered preferable for the purpose of preventing nocturnal attacks.*

ERYTHROL TETRANITRATE MERCK

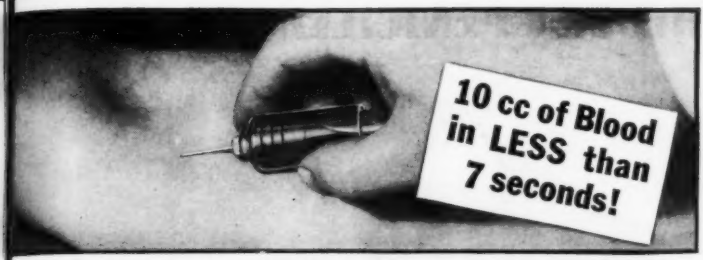
(ERYTHRITYL TETRANITRATE)

Council *Accepted*

MERCK & CO., Inc. RAHWAY, NEW JERSEY

Manufacturing Chemists

MERCK MERCK



Gain these SIX *Advantages* with The B-D VACUTAINER*

1 NO BLOOD TRANSFER NECESSARY — Blood is drawn from vein through needle into Vacutainer — where it remains for centrifuging and tests without need of transfer, also eliminating danger of outside contamination.

2 ADAPTABILITY — B-D Vacutainer tubes are available in a variety of sizes to fit most standard tests. They are supplied with or without anticoagulant.

3 HIGH QUALITY OF BLOOD — Delivers the quality and quantity of blood to the laboratories that they have always wanted but have not always received.

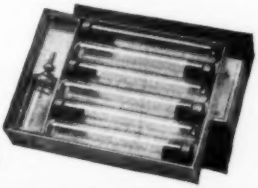
4 SPEED — 10cc of Blood in less than 7 seconds — under normal conditions. Speed of Vacutainer may permit one technician to do the work of two using other methods.

5 LOW COST — Original cost of equipment compares favorably with any other method. B-D Vacutainer saves cost of syringe, tube, cork, washing, scouring, sterilization, and other preparations for use. Less handling means less danger of breakage.

6 CLEANLINESS — Closed container eliminates contamination or possible spillage. Excess vacuum, after sufficient quantity of blood is taken into tube, automatically sucks residual blood from needle cannula into Vacutainer.

*A New Vacuum Tube device for collecting blood samples.
Write for folder showing Vacutainer in use.

Ask your dealer for the B-D Vacutainer Physician's outfit (#3201) containing 1 dozen tubes, a holder and an adapter for use with your own selection of needle.



No. 3201 Outfit

B-D PRODUCTS
Made for the Profession

BECTON, DICKINSON & CO., RUTHERFORD, N. J.

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PENICILLIN SODIUM—amorphous and crystalline forms: Vials containing 100,000, 200,000, 500,000, and 1,000,000 units.

PENICILLIN IN OIL AND WAX: 100,000, 200,000, and 300,000 units per cc.—5-cc. vials; also, 300,000 units per cc. in 10-cc. vials, and 1-cc. cartridge with needle.

TABLETS PENICILLIN CALCIUM (Buffered): 50,000- and 100,000- unit tablets, individually sealed in aluminum foil. Boxes of 12 and 120.

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393 SEVENTH AVE., NEW YORK 1, N. Y.

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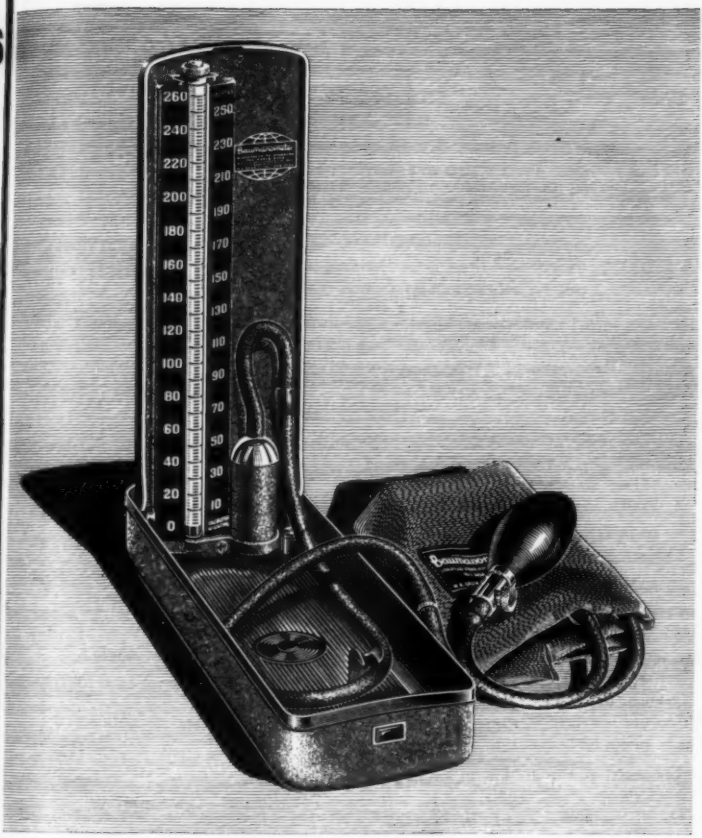


The KOMPAK Model Lifetime Baumanometer offers everything desirable in a bloodpressure instrument. It is *scientifically accurate, simple to use and carry, durable and attractive.* Like all Baumanometers, it functions on the immutable law of gravity . . . the fundamental principle by which all other types of bloodpressure apparatus must be periodically checked for accuracy. That is why it is *the instrument of choice* of a vast majority of the medical profession the world over.

W. A. BAUM CO., INC. NEW YORK 1

SINCE 1916 ORIGINATORS AND MAKERS OF BLOODPRESSURE APPARATUS EXCLUSIVELY

Yes
YOU CAN USE A BRAND NEW TOWEL FOR EVERY PATIENT!

Disposable Professional Towels are soft, sanitary, and amply strong for general office use. Made from Masslinn* non-woven fabric with the added protection of a cellulose crepe backing. They are sufficiently large (13½" x 19") to be used for drying face and hands, or as a protective towel, wipe, wrap for sterilizing instruments, on baby scales, trays, etc.

Professional Towels are low in initial cost (approximately 1½¢ each), and *there is no upkeep;* just use once and discard — that's all!

*Trademark of Chicopee Sales Corporation's non-woven fabric.

And Now...a New
CONVENIENT DISPENSER
for your Johnson & Johnson
PROFESSIONAL TOWELS

Holding forty towels, this sturdy, all-metal dispenser attaches to any wall surface, requiring only 7¾" x 5½" of wall space. Saves valuable cabinet space—and puts these handy towels just where you need them for greatest convenience and efficiency. Order through your dealer.

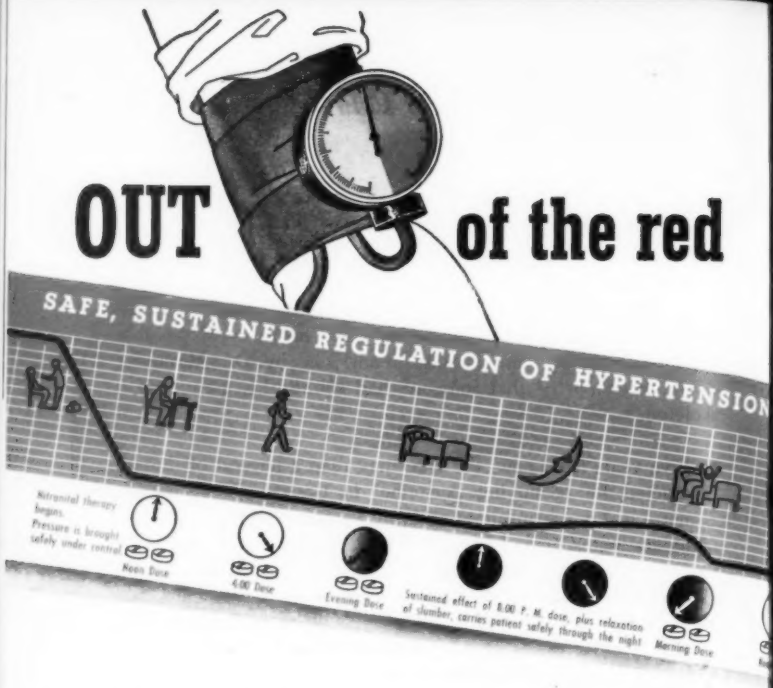
Johnson & Johnson
DISPOSABLE PROFESSIONAL TOWELS

Panorama

▶ "Assembly line medicine" is hit by Navy's Deputy Surgeon General H. L. Pugh. He wants medical schools to teach the humanities as well as the sciences so future doctors will regard their patients as human beings, not merely as "cases" . . . Malverne, N.Y., police, who thought they had heard every possible sort of complaint, were handed a new one by Dr. Alexander Zabin. He reported that someone had robbed his garage—of a skeleton.

▶ "Five years from now, the U.S. may reap a harvest of disease contracted by occupying personnel in Germany," warns Dr. Esmond R. Long, consultant to Army Surgeon General . . . Fifty-eight graduates, including four women, signed up to get Cook County (Chicago) Hospital's new general-practice interneship off to a flying start . . . First permanent Sister Kenny clinic has been dedicated in Centralia, Ill.; next will be in Brussels, Belgium . . . Survivors of atomic blasts in Nagasaki and Hiroshima to be put under long-term study by Atomic Energy Commission and National Research Council. Aim is to find out what effects radiation has on heredity.

▶ Dubbing himself personal physician to "the King of Africa and the King of Liberia," John Moses, New York Negro, did a brisk business in "atomic medicine" among Harlem residents until police arrived. Judge gave him six-month residency in city prison . . . Prostate Pete enthusiastic about new device that automatically switches on night light when user gets out of bed, switches it off when he gets back in . . . Dr. Paul R. Hawley, V.A. medical director, recently helped dedicate the first all-physician American Legion post in the country, at Newark, N.J. . . . Doctors and pharmacists of Kent County, Mich., aired their pet peeves at a joint meeting, then set up a committee to promote closer cooperation . . . Council on Physical Medicine, AMA, again warns that its acceptance of a germicidal lamp does not imply approval of its use in offices, waiting rooms, restaurants,



Vasorelaxation produced by Nitranitol is GRADUAL, avoiding the dangerously abrupt blood pressure fluctuations of the quick-acting drugs.

The hypotensive effect of Nitranitol is PROLONGED, each dose overlapping the one before—permitting maintenance of a relatively constant pressure.

The negligible clinical toxicity of Nitranitol, making it SAFE for use over an indefinite period, is in contrast to the cumulative toxicity of the thiocyanates.

Gradual, Prolonged, Safe Vasodilation with

NITRANITOL

T M. REG U S. PAT OFF

Nitranitol contains ½ gr. mannitol hexanitrate in each scor tablet. Dosage is 1 to 2 tablets every four hours. Available hospital and prescription pharmacies in bottles of 100 and 10

For cases requiring sedation in addition to vasodilation.

NITRANITOL
WITH
PHENOBARBITAL

Each scored tablet contains ½ gr. mannitol hexanitrate and ¼ gr. phenobarbital. Bottles of 100 and 1000.

MERRELL
1828

THE WM. S. MERRELL COMPAN
CINCINNATI, U. S. A.

or other places of public assembly . . . Straws in the wind: More indigents and semi-indigents are seeking hospitalization and fewer supposedly solvent persons are paying their hospital bills, says American Hospital Association on basis of reports from administrators.

▶ In need of a community hospital, farmers around Garrison, N.D., contributed a tithe of their wheat crops toward building it . . . National Federation of Small Business, after polling its 119,000 members, says 13 per cent are for Wagner-Murray-Dingell bill, 85 per cent opposed, 2 per cent undecided . . . Washington, aware that Sen. Robert F. Wagner is not a well man, questions his announced determination to get back into thick of fight for "liberal" legislation.

▶ New York Sun notes that AMA plans to give gold medal to some general practitioner who has rendered exceptional service to his community, and muses: "The family doctor sees shining from the eyes of his patients a light of gratitude which seldom penetrates the laboratories where great therapeutic discoveries are made. It is this light which helps him bear the tremendous strain of responding to calls at all hours. Beside it, even the most pretentious gold medal must seem relatively insignificant" . . . Long-delayed new edition of American Medical Directory will probably be distributed next fall . . . Methodist and Mercy hospitals, Gary, Ind., which have long admitted Negro patients, began last month to accept applications for staff membership from Negro physicians . . . In New York City, 100 Negro doctors, protesting against "Jim Crowism" in local hospitals, teamed up and bought a fifty-four bed institution.

▶ Fifty-seven per cent of Americans dread cancer more than any other disease, says George Gallup. Only five in 100 fear heart disease, he reveals, although it is country's No. 1 killer . . . National Association of Women Lawyers will press state legislatures to remove all indication of illegitimacy from birth certificates; only nine so far refrain from stigmatizing child . . . District of Columbia medical society is latest to require a pre-membership indoctrination course . . . Hospitals being told they'd better undertake real narcotic control in place of hit-or-miss methods that permit drugs to "disappear" from stock.

• EFFECTIVE • SLOW DISSOLVING • PLEASANT TASTING

Sulfalozenge "Rorer" provides relief in cases of pharyngitis, mild forms of tonsillitis, and in other oropharyngeal infections susceptible to such sulfonamide action.

Each Sulfalozenge contains:
1½ grains of sulfathiazole
1½ grains of sulfadiazine

The suggested dosage is one Sulfalozenge every one or two hours between meals, to be dissolved slowly in mouth, not chewed. A soothing effect is noticeable to the patient shortly after administration and complete relief from the inflammation is usually obtained within 48-72 hours. Write for professional samples and literature. William H. Rorer, Inc., Drexel Bldg., Independence Square, Phila. 6, Pa.

To be dissolved slowly in mouth, not chewed. Available in bottles of 100 lozenges

Sulfalozenge

RORER

Est. 1910

37 YEARS OF PAINSTAKING, SCIENTIFIC CARE TO INSURE DEPENDABILITY

Portrait

of a

sore throat

2 hours after intranasal instillation of

Paredrine-Sulfathiazole Suspension

The Suspension — instilled intranasally—provides rapid relief in sore throat for 2 reasons:

1. Part of the Suspension is swept beneath the turbinates, where it destroys bacteria before they reach the nasopharynx and intensify the infection.

2. Part of the Suspension drifts downward over the nasopharynx, forming a thin blanket which produces prolonged bacteriostatic action at the site of infection.

Smith, Kline & French Laboratories, Philadelphia

Paredrine-Sulfathiazole Suspension

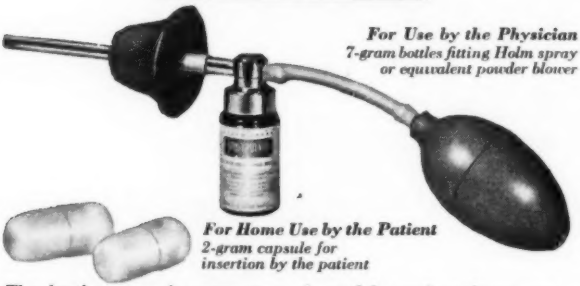
vasoconstriction in minutes...
bacteriostasis for hours

Introducing

ARGYPULVIS

a new adaptation of ARGYROL *for*

Trichomoniasis



For Use by the Physician
7-gram bottles fitting Holm spray or equivalent powder blower

For Home Use by the Patient
2-gram capsule for insertion by the patient

The development of ARGYPULVIS extends to an important new field of usefulness—the *protozoacidal*, *bacteriostatic*, *detergent* and *demulcent* properties of ARGYROL . . . long recognized by the profession as an efficient, dependable aid in treating infections of the genito-urinary tract.

A new approach to the treatment of Trichomoniasis has been devised, and the effectiveness and special advantages of ARGYPULVIS pointed out, together with a complete absence of observed harmful by-effect.*

Composition . . . Physical Properties . . . Forms

ARGYPULVIS contains powdered ARGYROL (20%), Kaolin (40%) and Beta Lactose (40%) . . . finely milled, to provide the fluffiness which makes for easy insufflation, and with an attraction for water which promotes fast action.

ARGYPULVIS

Is Produced In Two Forms

7-gram bottles in cartons of 3

2-gram capsules in bottles of 12

INTRODUCTORY TO PHYSICIANS: On request we will send professional samples of ARGYPULVIS (both forms) together with a reprint of the Reich, Button, Nechtow report.

Write to: A. C. BARNES COMPANY, NEW BRUNSWICK, N. J.

**Reich, Button and Nechtow, "Treatment of Trichomonas Vaginalis, Vaginitis," Surgery, Gynecology and Obstetrics, May 1947, pp. 891-896*

Speaking Frankly

Heady

I'm still pondering the plight of that lovely girl encumbered with man's legs in your July cartoon. It reminds me of the remark of a bald-headed colleague who, after completing his examination of a patient's leg injury, said, "She has more hair on her leg than I have on my head."

M.D., New York

Browbeaten

Your September article indicating how unintentional misrepresentation can void an insurance contract suggests that sickness and accident policies may be stacked against the would-be policyholder. In some instances, it appears that the company is trying to browbeat the doctor, too.

One "Physician's Hospital Statement" has fifty-one blank spaces to fill in. In the top corner it says impudently, "This is the doctor's *personal* statement and is *not* to be completed by any other person." I don't let patients dictate how I shall run my business and I can tolerate such dictation from strangers even less.

At the bottom of the page is this insolent threat: "If [each and every question has not been answered] it will be necessary to return the form to you." My reaction to this is to hitch the wastebasket a little closer in anticipation of the form's return.

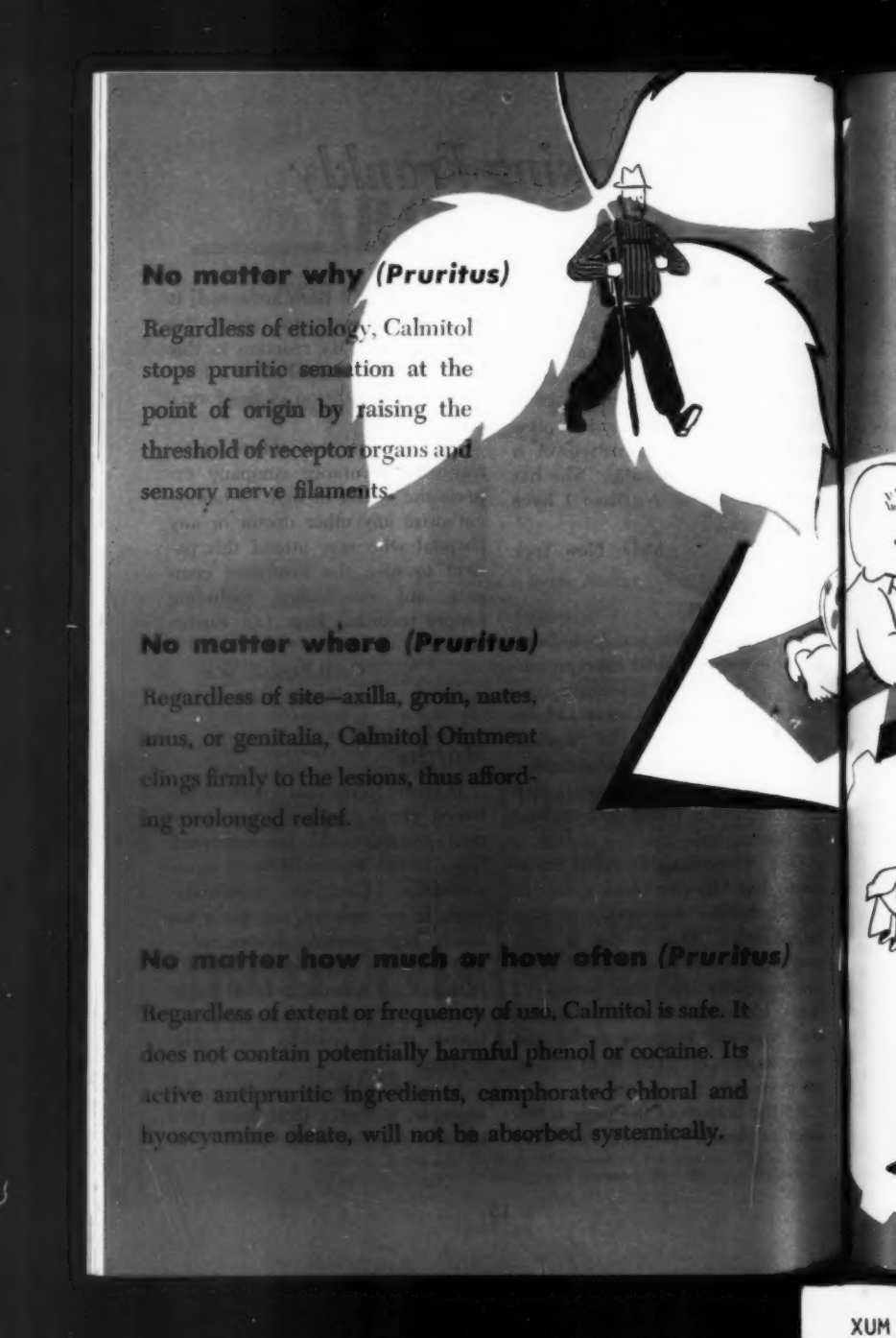
Then there's this absurd statement the insurance company expects the doctor to sign: "I hereby authorize any other doctor or any hospital who may attend this patient to give the insurance company any information, including history records." Page Der Fuehrer!

Cecil Riggall, M.D.
Prairie Grove, Ark.

Muffler

It seems to me that relations between physicians and pharmaceutical houses could be improved. Sales tactics especially need re-examination. Company representatives, in my opinion, are using too much high-pressure salesmanship and reflecting not enough scientific background. A sounder bond might develop if the pharmaceutical houses would consider these suggestions:

In quoting on 10 c.c. vials, for example, just give their price plus tax and shipping costs. Don't both-


No matter why (Pruritus)
Regardless of etiology, Calmitol stops pruritic sensation at the point of origin by raising the threshold of receptor organs and sensory nerve filaments.
No matter where (Pruritus)
Regardless of site—axilla, groin, nates, anus, or genitalia, Calmitol Ointment clings firmly to the lesions, thus affording prolonged relief.
No matter how much or how often (Pruritus)
Regardless of extent or frequency of use, Calmitol is safe. It does not contain potentially harmful phenol or cocaine. Its active antipruritic ingredients, camphorated chloral and hyoscyamine oleate, will not be absorbed systemically.
XUM

er with the cost per patient per day for a six-month treatment.

Tone down exaggerated claims. Six different companies lately have proved (?) that their iron-liver mixture raises the hemoglobin faster than similar preparations of four competitors.

Don't tell me that Professor Schweissfuss at Ponderosa Clinic has proved that your preparation is superior to all others. I don't like the implication that I am a complete moron if I have never heard of Professor Schweissfuss.

M.D., Colorado

Starving

Doctors talk about the shortage of nurses but don't do much about a living wage for them. An R.N.'s biggest disappointment is finding that after three years' training for nursing, he or she earns less than a waitress or grocery store clerk, a dishwasher or mechanic.

When the medical profession helps the nurses get a salary they can live on, it can expect more nurses and superior ones.

R.N. (male), California

Ostriches?

Several times I have had patients with intractable headaches or pains in the neck, back, or joints that I was unable to stop. They have gone to chiropractors or osteopaths and have gotten immediate relief. Yet I don't think any of these patients were neurotic.

This is probably heresy, but I often wish I knew more about those

WHAT'S THE COST OF A "GOOD" MEAL?

What some people consider a "good" meal is too often not good for them—and acid indigestion is frequently an ultimate part of the price they must pay.

When such cases arise, you'll find quick-acting, pleasant-tasting BiSoDoL a truly effective countermeasure. It has the fine reputation for results and wide medical acceptance which you have a right to demand of any medicament you recommend.

May we suggest you try it?

BiSoDoL

POWDER • MINTS

WHITEHALL PHARMACAL COMPANY, 22 E. 40th ST., NEW YORK 16, N.Y.

two "rackets." I stand unconvinced that it's all just a lot of hocus-pocus. I feel that those fellows have something we've missed the boat on. Why can't we smarten up and learn it?

Perhaps some of those traitorous M.D.'s who are teaching in institutions of chiropractic and osteopathy could give us the answer. Why should we play so smug? Who knows but we may be playing ostrich?

Wilber S. Rose, M.D.
Olmstedville, N.Y.

Reader Rose may find a few of the answers on page 139, this issue.

Debunkers

Will you please sketch briefly the background and purpose of an organization called the National Society for Medical Research?

M.D., Iowa

The NSMR was formed in 1946 to combat the anti-vivisectionists' threat to medical research. Its membership includes practically every national scientific organization and medical college in the United States. The society is headed by Dr. A. J. Carlson of the University of Chicago. It aids educators and publicists in verifying information on medical research.

Peanutty

Some time back I charged a man $6 for a house call after 11 P.M. That fee was $1 more than it would have been ten years ago. The patient grumbled that my ordinary day fee of $4 would have been more appropriate.

On the way home, my car broke down and had to be fixed. The mechanic did me a "favor" by charging me his old rate of $15 for the repair job. This same mechanic had recently been charged only $10 for two home visits (including electrocardiography) by one of the best heart men I know.

Today we have to pay $1 for a haircut that in 1940 cost two bits. Yet the tentative fee schedule of the Veteran's Administration in my area allows $15 for "complete examination of heart, including electrocardiogram."

Shall we work for peanuts?

M.D., New York

Slip

In your July issue you stated that Congressman Judd sat in on the Jamestown, N.D., health workshop held in December, 1946. At no time during the workshop was Congressman Judd in attendance. To my knowledge, he has never been near our headquarters building.

Glenn J. Talbott, President
North Dakota Farmers Union
Jamestown, N.D.

Right. The health workshop that roused Congressman Judd's curiosity about "propagandizing" by Federal employes was the one he attended at St. Paul, Minn.

gh Vitamin B Complex Content of

LI-BETARON

Quickens Hemoglobin Response to Iron Therapy

For Unusual Potency Prescribe

WARREN-TEED

Li-Betaron

for Secondary Anemias

leficiency conditions, vitamin B complex stimu-s normal gastric secretion — the hydrochloric l thus produced is necessary to maximal absorp- and utilization of iron.

Each fluidounce contains:

Liver Concentrate 1:20	1.42 Gm. (21.875 grs.)
Iron and Ammonium Citrates, Green	2 Gm. (30 grs.)
Thiamine Hydrochloride	18 mg.
Riboflavin	6 mg.
Nicotinamide	60 mg.
Pantothenic Acid	4.5 mg.
Vitamin B_6 (pyridoxine)	1.5 mg.
Alcohol	10%

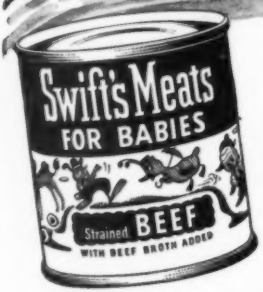
and other vitamin B complex factors as found in liver. The naturally occurring vitamin B complex factors in the liver concentrate have been fortified with synthetic thiamine hydrochloride, riboflavin, nicotinamide, calcium pantothenate and pyridoxine hydrochloride

WARREN-TEED

Pharmaceuticals

WARREN-TEED PRODUCTS COMPANY • COLUMBUS 8 • OHIO

Here's tempting, real meat for patients on soft, smooth diets!



Swift's Strained Meats
specially prepared— fine enough for tube-feeding

Here's protein-rich meat that patients on soft, smooth diets can eat and *enjoy!* Swift's specially prepared Strained Meats provide an excellent base for a high-protein, low-residue diet—in a form that is chemically and physically non-irritating. There are six different, highly palatable meats: beef, lamb, pork, veal, liver and heart . . . readily accepted by most patients, even when normal appetite is impaired.

The individual particles of Swift's Strained Meats are fine enough to pass through the nipple of a nursing bottle—may easily be used in tube-feeding. Swift's Strained Meats are prepared with expert care from selected, lean U. S. Government Inspected Meats. They are ready to heat and serve. Each tin 3½ ounces.

All nutritional statements made in this advertisement are accepted by the Council on Foods and Nutrition of the American Medical Association.

Swift's Diced Meats

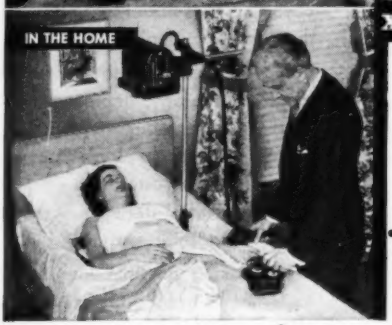
For patients on a soft, high-protein, low-residue diet who can eat meat in a form less fine than Strained, Swift's Diced Meats—juicy, tender cubes—offer an excellent, appetizing source of proteins, B vitamins and minerals. Five ounces per tin.

SWIFT QUALITY FOODS

If you wish samples of Swift's Strained and Swift's Diced Meats together with complete information, write: Swift & Company, Dept. B.F., Chicago 9, Ill.

SWIFT & COMPANY • CHICAGO 9, ILLINOIS

SUBSTANTIATE YOUR DIAGNOSES
WITH THIS G-E PORTABLE X-RAY



This powerful, 100 per cent shockproof x-ray, atop your office desk or in the home of your inambulant patients — provides you with a sure way of obtaining information you desire to substantiate your diagnoses.

It's easy to operate. With its simplified control you can easily and quickly make examinations of possible fractures, gross pathologies and foreign bodies with satisfying results.

GENERAL ELECTRIC X-RAY CORPORATION

It's the lightest unit of its compactness and flexibility ever built—comes in a neat carrying-case . . . is easy to assemble and disassemble. And because of its low cost is well within reach of every practicing physician.

To learn all the advantages of owning this popular G-E Portable X-Ray, clip this coupon now . . . mail it today.

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Send me G-E "Portable X-Ray" booklet

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***"Bearing lamps, we shall find the way."**

Down through the ages mankind has sought more light, more understanding to explain the facts about our complex physical universe . . . to let humanity walk erect and unafraid.

Today the inquiring mind—represented by the research scientist—is rapidly extending the boundaries of knowledge on all frontiers. To shed new light on the behavior and potentialities of one of the great carbohydrates, sugar, the sugar industry established the Sugar Research Foundation.

Recognizing that only through objective studies can true progress be achieved, this international non-profit group has been free to set up a program of wide scope. Its aim: to discover the *facts* about sugar and make them freely available.

Now extending into the fields of medicine, biology, dentistry, organic chemistry, micro-biology, physiology and numerous technologies, dozens of independent investigators at universities and laboratories are working under Foundation grants-in-aid.†

By making possible long needed experiments to fill gaps in our knowledge, and by systematically collating all available information, it is hoped that sugar may eventually have a more clearly defined place in the diet and broader usefulness as an industrial raw material.

†Information concerning the organization and progress of this program will be sent on request.

SUGAR RESEARCH FOUNDATION

A NON-PROFIT INSTITUTION **52 Wall Street, New York 5, N. Y.**

do something about

Cold Sequelae *before* infection develops

The best time to fight the sequelae of the common cold is *before* the infection develops . . . *before* the colds-susceptible patient has succumbed to the debilitating effects of its secondary invaders.

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Oravax is available in bottles of 20, 50 and 100 tablets. For best results, prescribe 1 tablet daily for 7 days, then 1 tablet twice a week throughout the winter.

Improved Oravax now provides an even wider range of protection against this secondary invasion, for each small enteric-coated tablet contains 60 billion killed organisms and the soluble (ecto-) antigens from 8,625 million:

D. pneumoniae, Types I, II, III, VII and VIII (5,000 million each)	25,000 million
and the soluble antigens from (750 million each)	3,750 million
Streptococcus hemolyticus, Type A	10,000 million
and the soluble antigens from	1,500 million
Streptococcus viridans	5,000 million
and the soluble antigens from	750 million
H. influenzae, Type a	2,500 million
and the soluble antigens from	375 million
K. pneumoniae, Type A	5,000 million
and the soluble antigens from	750 million
Staphylococcus aureus and albus (5,000 million each)	10,000 million
and the soluble antigens from (750 million each)	1,500 million
N. catarrhalis (no soluble antigens)	2,500 million

There are, admittedly, differences in medical opinion regarding the value of oral bacterial vaccines. Moreover, some individuals appear resistant to any type of respiratory vaccine. However, the published reports of a number of clinicians indicate that Oravax will, in a high percentage of cases, build an important measure of protection against secondary invasion by the organisms included in the formula. These results would certainly seem to warrant a thorough trial of Oravax, as a means of reducing the severity and duration of cold sequelae in your patients.

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Sidelights

"Never underestimate the power of a woman," the ads keep telling us. No one who has watched the women's auxiliary of a large medical society in action needs that advice. As a group, doctors' wives have shown themselves influential supporters of medicine's campaigns. Individually, they have become compelling spokesmen for medicine in such groups as the PTA, women's clubs, and civic organizations.

Considering this background, it's a surprise to discover some regions where the slogan might well be taken to heart. In one eastern state, for example, eight county medical societies still have no women's auxiliaries. Keeping our greatest potential ally under wraps is no way to stir up support among the public at large.

Suppose someone asked you to name the most important type of insurance for a private practitioner. You'd probably say, "Ordinary life."

If so, it may surprise you to learn that a number of insurance men think otherwise. More essential than life insurance, to their way of thinking, is protection against disablement from ill health or from accident.

Look at it this way: When the breadwinner dies, his family needs funds. When he becomes disabled, money is required not only for his family but for his own support as well. In terms of hard cash, long-term disability can easily pose a greater threat than sudden death.

Most working men nowadays get a limited form of disability protection from the moment they first punch a time-clock. But professional people, largely untouched by compensation laws or by employe benefit plans, face the necessity of shifting for themselves.

You may have heard that disability insurance can no longer be bought. That's not true, although the number of companies issuing it has declined steadily. A few sound, reliable companies continue to offer such coverage. Only hitch is, it must be bought in conjunction with life insurance. The prevailing ratio is $5 a month disability income for every $1,000 face value of life insurance; and it may not suit your plans to carry, say, $80,000 of straight life in order to get $400 a month disability protection.

In that case, pick a separate

health and accident policy. A good one will pay you disability benefits of $400 a month for a maximum of eight years. If you take out a twenty-year, noncancelable policy when you are 40, the premiums will set you back about $270 a year.

Steep price? Sure. But think of the alternative. What would happen if an accident tomorrow laid you up for six months? Or if a disabling illness took you away from your practice for a couple of years or even for life? The prospect should send many a thoughtful practitioner into a prompt huddle with his policy-and-premiums man.

The nights we spent poring over uncollected accounts and mailing out fourth notices during the last depression seem now like a bad dream. Yet it's a dream that can recur. And before it does, some of us will see the telltale signs: Receipts will slacken—quite a bit sooner than those of business in general.

Why sooner? Because John Q. Public knows that if his time payments on a new washing machine fall behind, it won't stay in his basement long. So installments due on such things get priority. While patients' cash reserves last, physicians won't feel the pinch. But chances are they'll feel it earlier than most other occupational groups.

A report from the Institute of Life Insurance shows that the consumer public is now going into debt twice as fast as ever before. Most

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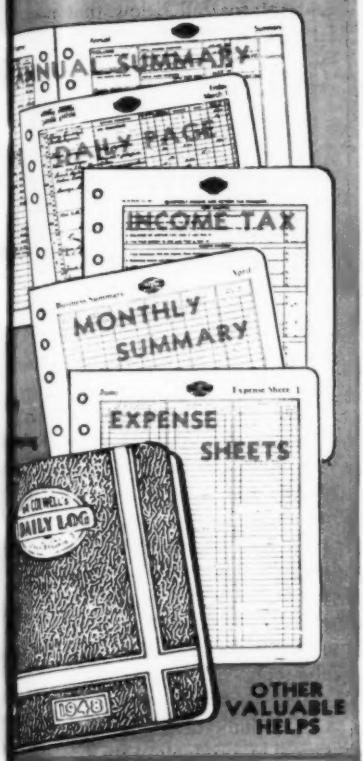
YOUR
ET EARNINGS



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In the response to the demand for simplified records, doctors everywhere are turning to the DAILY LOG as a practical solution. Fourteen forms are designed to make income and expense figures flow in 1-2-3 order, giving you monthly *net income* statements. Daily pages list each call made, cash received, or charge made. The annual summary is praised by accountants as a marvel of efficiency.

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XUM

business-cycle pundits say this will accelerate inflation. It will lead also to deflation—of medical incomes.

The average physician collected 87 per cent of his accounts in 1943, according to the Fifth MEDICAL ECONOMICS Survey. Before his current returns fall below that mark, let him put the spurs to his billing system and tighten the reins on any credit he extends.

Figures this magazine has published in recent months underscore the speed with which voluntary health insurance is spreading. Even so, some people are inclined to let their imaginations run ahead of the facts.

Take, for example, the 61 million enrollments listed by all voluntary health protection plans. At first glance, you might think the plans were over the hump. Hasn't total eligible population been estimated at only 100 million? But wait:

Overlapping within that 61 million reduces the total number of persons covered by an estimated 25 per cent. And much of that coverage is fractional, since many plans offer only limited cash benefits or exclude common medical expenses.

Such limitations are, of course, normal by-products of the trial-and-error method, without which no insurance scheme can succeed. But they're worth keeping in mind. They make it clear why the profession's full support is still needed to keep voluntary health insurance moving ahead.

. . . But you ought to see her *Mother!*

Mother's eyes are big as saucers, too . . . especially when she watches her baby enjoy spoon after spoon of cereal. But why the big surprise? After all . . .

90% of the babies who start on Gerber's Cereals—stay with them according to a recent survey.

What's your guess? Why do so many babies continue happily with Gerber's Cereals—usually their *first solid food* after milk?

Here are some hints: *extra fine texture* and such *pleasing flavors.* And let's not overlook the appetite-tempting variety of Gerber's Cereal Food, Strained Oatmeal and Barley Cereal.

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"one nervous woman

. . . can give rise to more diverse, undiagnosed and undiagnosable complaints than a whole pathological ward."

Harding, T.S.: M. Rec. 160:198 (April) 1947.

For the many patients, especially women, who complain of nervous tension throughout the day and wakefulness during the night, ESKAPHEN B ELIXIR is an ideal preparation.

Eskaphen B Elixir

For the nervous patient with poor appetite

provides—in delightfully palatable liquid form—both the calming action of phenobarbital and the tone-restoring effect of thiamine.

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. . . SO SOME CHILD PATIENTS ARE BRATS!

We can't tell you how to reform them, of course. But here's a suggestion that will make things easier for you and the parents in those cases for which the administration of sulfadiazine is indicated: Prescribe Sulfadiazine *Dulcet* Tablets. The brats will *like* them. So will cherubs. And so, for that matter, will many adults who have difficulty in swallowing tablets and capsules, or who should use sulfadiazine tablets as troches for local effect. ● Sulfadiazine *Dulcet* Tablets are candies . . . in appearance, in taste, in odor, and in the way they melt in the mouth. Yet they are accurately and scientifically standardized to produce the desired therapeutic result. Sulfadiazine *Dulcet* Tablets are stocked by prescription pharmacies in two sizes: 0.16 Gm. (2½ grs.), and 0.32 Gm. (5 grs.). They may be chewed, dissolved on the tongue, or taken in a little water. Prescribe the same dosages as you would with conventional sulfadiazine tablets. Would you like a physician's sample? Just drop a line to ABBOTT LABORATORIES, North Chicago, Illinois.

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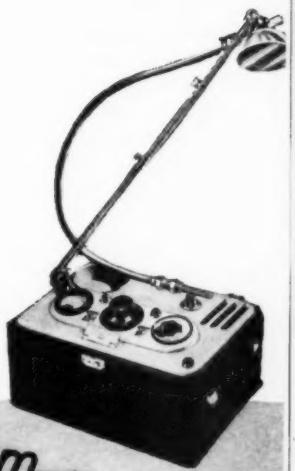

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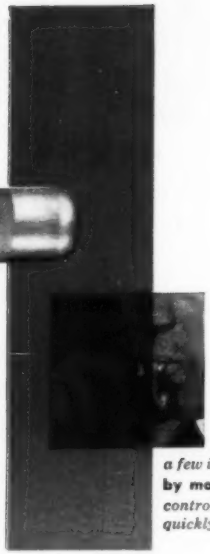

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by mouth
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The anesthetic-analgesic vapor* from Eskay's Oralator is delivered by inhalation through the MOUTH directly to the lining of the trachea and larynx—where it acts almost instantaneously to control cough. The patient gets relief in a matter of seconds.

This local therapy produces no appreciable systemic effects, and thus avoids the depressant action of sedatives and narcotics.

Eskay's Oralator is outstandingly convenient—easy to use anywhere at any time. Your patients will appreciate your prescribing this quick-acting oral inhaler. *Smith, Kline & French Laboratories, Philadelphia.*

Eskay's Oralator

A revolutionary advance in the treatment of cough

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Editorial

Missing Links

Opinion pollsters tell us that only one American in three favors tax-financed medical care for all. But a casual observer at hearings conducted last summer by a Senate health subcommittee could have been pardoned for thinking otherwise. In opposing the Wagner Bill, medicine looked like a lonely minority. A mere handful of non-medical organizations rallied to our side.

Which points a finger at one of the profession's great twilight areas: its relations with outside agencies. Organized medicine, because of its past performance, has been charged more than once with "isolationism." Now that some of our leaders report a widening split between the profession and the public, our outside ties may well serve as lifelines.

How can we expand our orbit? By going more than half way toward those who could be our active allies and toward those who need a better understanding of our problems.

To most business and professional groups, undue Federal control is anathema. They are willing, therefore, to go to bat for free enterprise at the drop of a hat. Yet what do we find? That our relations with such groups are largely unexplored.

Working hand in glove with chambers of commerce, employers' associations, and other industrial and professional bodies could obliterate much of organized medicine's isolationist tinge. But there's an even more vital job for us among the consumers of medical care.

For example, no rift has been wider than that between medicine and labor. Yet if the unions got the idea that we would work with them to find medical security, their support of the Wagner Bill might cool. Conferences with AFL and CIO leaders would almost certainly turn up areas of agreement.

Other groups that speak for America's patients deserve cultivating, too. Closer collaboration with fraternal organizations, women's clubs, and civic groups would unquestionably win us new friends.

Should teamwork be attained through a national health congress or on a group-by-group basis? That's a question still to be solved. But to get joint effort of any sort under way, someone has to make

the overtures. Medicine would reap incalculable benefits if the AMA were that someone.

One midwestern medical society has put what we're shooting for into phrases that hit home: "Our national association must be willing to concern itself more than previously with problems of national importance, even if they be only a little concerned directly with health. The American medical profession having now come of age, the organization which represents it must be a part *of* the total society of this nation, not apart *from* it."

In certain fields the AMA has already established close rapport with outside groups. Its teamwork with the National Education Association has done much for school health training. Its liaison with some Government agencies on health surveys has been commendable. Perhaps its prize package has been the National Conference on Rural Health, which each year brings together spokesmen for farm groups, labor unions, health cooperatives, rural consumers, and the medical profession.

Starting more such conferences would give AMA prestige a new lift. It would also cast medicine in its proper role of health leadership. The idea has too many advantages to be passed over lightly.

—H. SHERIDAN BAKETEL, M.D.

Central Agency for Prepay Plans Maps Long-Range Strategy

AMCP works with Blue Cross to uproot enrollment snags

To boost their enrollment toward Blue Cross heights, medicine's prepay plans had long needed national cohesion. Last month they were getting it in good measure. The supplier: Associated Medical Care Plans, an 18-month-old agency backed by forty-four nonprofit plans.

AMCP had put ten committees of prepay experts to work on some of health insurance's knottiest problems. A few months of grappling weren't enough to turn up many answers. But with the help of a $40,000 annual income and a new alliance with Blue Cross, AMCP hoped to make its collective brow-furrowing show results on the 1948 enrollment scoreboard. Even if the AMA-sponsored agency carried out only half the big ideas broached at its recent annual meeting, physicians could look for a marked increase in the number of their insured patients next year.

How will AMCP turn this trick? Mainly through behind-the-scenes work on administrative obstacles that hamper enrollment. Still under wraps is the national promotion campaign AMCP will eventually use to fan public interest in prepaid medical care. Officers of the agency believe each plan should take care of its own public relations until problems in interplan relations have been solved.

Coordinating the far-flung activities of its member plans is, in fact, AMCP's biggest job. It is up against such posers as: (1) how to arrange payment for plan subscribers taken ill outside their home state; and (2) how to transfer subscribers from one plan to another with totally different eligibility standards, premiums, and benefits.

UNIFYING TOUCH

To encourage interplan give-and-take, AMCP is setting up twelve new district organizations. Through them it hopes to get working agreements among local plans that can be translated ultimately into national agreements. Joint committees within each district will study specific phases of prepayment in action. Although one district organization has already been set up

in the Southwest, most won't get going until mid-1948, when the AMCP constitution is due for a revamping.

Another new development is AMCP's hand-in-glove work with the Blue Cross Commission, its counterpart for hospitalization plans. The two are mulling over the idea of a separate national enrollment corporation. Its primary purpose would be to sell contracts (both hospital and medical) to business firms with employes in several states. The proposed unit might also sign up individuals in areas not now covered by any plan.

AMCP is also working with the Blue Cross Commission to get more uniformity in hospital plan procedure. In Ohio, for example, one medical plan has to make its operations dovetail with those of nine different types of Blue Cross plans. AMCP hopes the new district committees may be able to cope with such problems.

SOME M.D.'S LUKEWARM

One weak link in the prepayment chain, to AMCP's way of thinking, is the half-hearted support some plans get from local physicians. AMCP will ask state and county medical societies to help out here. Its chief antidotes: more time at medical meetings and more space in medical journals for discussion of prepaid medical care.

As for its relations with the AMA, the prepay agency has had to smooth out some rough spots. But differences of opinion between AMCP and the Council on Medical Service no longer cause open dispute, and an amicable working arrangement has been established. AMCP relies on several of the national association's services. Early next year it will call on the Bureau of Medical Economic Research to tackle some of AMCP's statistical work. Out of this AMCP hopes to get actuarial data that will help individual plans establish broader benefits and sounder premiums.

Though it's brimming with schemes for the near future, AMCP is also toying with long-range ideas. For example, what about the prepay plans' role under a Taft-type national health program? Presumably they would have to carry a huge new load. So AMCP has added that problem to its already overstuffed docket.

Partly for the training it will get, AMCP has taken on the job of writing a national administrative contract (excluding fees) for the eleven prepay plans that now play a part in veterans' home-town care. It will also put out a manual interpreting the contract. Not only will this project aid the V.A. program, AMCP officers think; it will give AMCP first-hand experience in working with tax-financed medical care schemes.

To Frank E. Smith, AMCP's lay director, goes much of the credit for the agency's great strides in

[PLEASE TURN TO PAGE 132]

Bad Debts as Income Tax Deductions

Unrepaid loans or worthless bonds may whittle down the tax you pay

If friends shun you when you cry in your beer over the money you've lent and never recovered, take heart. The income tax collector is a sympathetic fellow. Bad debts are among the deductions he allows you when totting up how much you owe Uncle Sam.

That doesn't mean you can deduct *every* unpaid debt. First, you must show that the money was loaned on an unconditional promise of repayment. Secondly, the debt must have become worthless during 1947. If it had no value at the close of 1946, or if there's a chance it will be repaid in 1948, you can't deduct it now.

These considerations mean that the $50 you slipped to a down-and-out friend can't be deducted, nor can that "loan" to your brother-in-law. You never really expected to be repaid, so for tax purposes they are gifts.

Classes of debts that are deductible include worthless bonds. If you hold registered or coupon bonds that have lost all value, treat them as long- or short- term capital losses.

A personal loan gone bad, like that $300 note Mr. X never repaid before leaving for parts unknown, is fully deductible. If you've compromised a loan—if you were forced to accept $100 as repayment in full for the $500 you loaned Mr. Z—the difference can be subtracted from your taxable income. Make the deductions under the tax form heading, "Losses from fire, storm, shipwreck, or other casualty, or theft."

Unpaid bills for professional services seldom count as bad debts. Most medical books are kept on a cash basis, and such bills aren't entered as income in the first place. No deduction is allowed because no tax has been paid on them in previous years.

In listing bad debts – whether they be unpaid bills, worthless bonds, or forgotten loans—be ready to prove that the money can't be recovered. The evidence must show that you've made a concerted attempt to collect (including a court trial when the debt is substantial). If, after that, the debtor still doesn't come across, the Treasury Department will honor your deduction.

—J. D. OBERRENDER

What the Courts Call 'Excessive Fees'

Typical cases show standards used to decide whether a doctor's fee is fair

When a patient claims your bill is too high and refuses to pay, you may decide to take him to court. If you do, you can be reasonably sure of a sympathetic hearing at least.

If you had a specific agreement with the patient, either oral or written, the court will usually take your side. If you didn't, the decision will probably go to you provided:

¶ Your fee is in line with those charged for the same type of work by similarly qualified men in your community.

¶ You have been reasonable in gauging the patient's ability to pay.

SLIDING SCALE

Contrasting decisions by New York and Wyoming courts illustrate these points. In the New York case, two surgeons of outstanding reputation performed a prostatectomy on an elderly out-patient at an upstate hospital. Thinking that the patient was without means, they asked no fee. A short time later, when the patient died, it was discovered that he had been wealthy. The surgeons jointly sued his estate for $2,000. After hearing other physicians testify that the two surgeons were of great skill and experience and that the fee was in line with their usual charge, the court decided in their favor. It took the position that had the patient revealed his true wealth he would have been expected to pay this fee or submit to surgeons of less skill and experience.

A Wyoming court, however, turned down two Denver, Col., surgeons who had asked $750 of a Wyoming sheep rancher for a prostatectomy. They collected $500. Suit for the difference was brought in Wyoming. On behalf of the rancher, a local physician testified that he had referred similar cases to Denver surgeons and that the usual fee had been between $250 and $500. Consequently the court held that $500 was enough.

SPECIALIST SUITS

Ordinarily a specialist commands a higher fee than a general practitioner. But a specialist must stay within his own field if he expects to charge a specialist's fee. Consider these three cases:

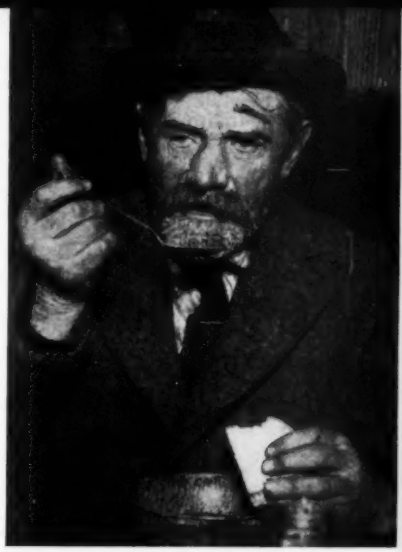
1. A young orthopedist was called to treat an elderly woman

for possible spasmodic torticollis. He visited her almost daily for a month, spending an hour or two with her each time. He made braces that relieved her pain somewhat, took blood tests, and accompanied her during visits to a radiologist. At the end of a month he called in an eminent neurologist who treated the patient for several weeks. A brain surgeon, called in by the neurologist and the orthopedist, operated on the patient, who died after the second operation.

The woman left an estate of $264,000. Her executor paid the neurologist $1,875 and the surgeon $1,250 without objection. The orthopedist's bill of $1,500 was rejected, however, as exorbitant. The trial court awarded the orthopedist only $262 because (a) he was a recent graduate of little experience and (b) while treating a neurological case, he did not have the status of a specialist and therefore was not entitled to a specialist's fee.

The appellate court, however, found that neither the disease nor the cause of death had been definitely established. Thus it could not be shown that the orthopedist had gone outside his specialty. Furthermore, the court observed that a young physician might in some cases be more competent than older men who had not kept up with the latest medical developments. Accordingly, the full fee of $1,500 was approved.

2. A surgeon whose close friend



Setting fees for patients at the bottom of the income scale poses no problem. But if a man can spend $1,000 on a polo pony, what's a fair charge, say, for paring his prostate? Medical books don't give the answer, but the courts sometimes do.

had attempted suicide attended him constantly for almost a week. When a transfusion was required, the surgeon was so fatigued that he selected a colleague to perform it. The patient died insolvent. His trustee in bankruptcy sued the surgeon for $2,000 which he had owed his friend. The surgeon, who had not previously submitted a bill, then counter-claimed for $2,500 for his services. The court held that the doctor must be compensated "rather upon the scale of charges for the services of a family physician than upon the much higher scale of services of an operating surgeon." The fee was therefore fixed at $750.

3. During a trial in New York an oculist was testifying for the plaintiff when the defendant was stricken by a heart attack. The oculist left the witness stand and administered artificial respiration. He continued this treatment for about twenty minutes until convinced that it was futile. The dead man left a large estate. The oculist submitted a bill for $500. The executors rejected the bill as excessive.

In a subsequent action to recover this fee, a medical witness testified to the oculist's skill and placed the value of his services at $500. Doctors testifying for the estate valued these services at $10-$15. They argued that the services rendered required no great skill and could have been performed even by a

medical student. The court allowed $15.

Thus a specialist must scale down his fee if he gives service for which his special qualifications are not needed. On the other hand, a general practitioner cannot raise his fee because he does work that normally is done by a specialist.

ENTER THE G.P.

A California physician, for example, was called to a hospital to attend an actor who had bronchial pneumonia. At the patient's request the physician remained at the hospital for twenty-three consecutive days. The patient then recovered sufficiently to permit his removal to a sanitarium for further treatment. For these twenty-three days the doctor sent a bill for $12,000. When the actor charged that the fee was excessive, the physician sued. But the court declared that since the physician was not a specialist, he was entitled to a fee in keeping with his customary charge as a general practitioner.

As most physicians know, if treatment is given with reasonable skill and care, the patient owes the doctor his fee regardless of the outcome of the case. A Texas decision illustrates this point. Two surgeons in Beaumont operated on a wealthy man for "acute and malignant appendicitis trouble." They attended him constantly until his death a week later. Ultimately a jury awarded them $2,000 for their services.

Handitip

Seasonal Gift

I have a special Christmas greeting for patients who have owed me $5 or less for over a year. In the Yuletide spirit, I present them with a *canceled* bill. Often, their return greetings include payment-in-full for the outstanding debt.

—M.D., WASHINGTON

One of the most difficult questions the courts have to decide is whether a physician's fee is reasonable when measured against the patient's ability to pay. What constitutes ability to pay was defined by a Louisiana court as a patient's means, not merely his income. The court gave its opinion when a surgeon sued a patient for $400 for a mastoidectomy. The defendant, a minor, had inherited $40,000 but was a student and earned no income. The court said he could pay the $400 and should.

A Washington court heard a number of medical men testify that there is a nationwide practice of charging about 10 per cent of a patient's annual income for a major operation. Nevertheless, to a physician who had brought suit the jury awarded $3,500. This was about 5 per cent of the defendant's presumed income and less than ¼ of 1 per cent of her known means.

—ARNOLD G. MALKAN, LL.B.

Cues for Handling Cancer Patients

A cancer specialist suggests ways to keep their hopes buoyed up

The telephone rings at 8:30 as I sit down wearily to dinner. There is no mistaking the fear and panic in the man's voice as he stammers: "Doctor, we've just come from our family physician. He says my wife has a cancer and has to be operated on within twenty-four hours. Can you see her right away?"

Futile to reason with a man in shock—to argue that if his wife had not gone to her doctor until next week, he still would have given her twenty-four hours' grace. Instead, I tell him to bring her to my office the following day—although I know the appointment schedule is full to bursting and that I will have to face the reproachful eyes of my office staff.

Six months earlier the patient had noticed a lump in her breast. She put off going to her doctor because she "was afraid he might give me bad news." This, in spite of the warnings of our recent cancer campaign. It was only when she discovered a mass in her armpit one morning that she felt compelled to act. She was then too frightened *not* to go to her physician.

It was obvious to him that she had a fully developed cancer. Suspecting that unless he took a strong line with her the patient might delay treatment still further, he proceeded to put the fear of God into her. Nothing short of blitz tactics will work with certain patients. However, the inevitable reaction is blind panic, with the patient, and often the family too, completely losing their heads.

How does one deal with a situation like this? I think the first, and most important, step is to dispel fear from the patient's mind. This can best be done by approaching her problem as if it were nothing out of the ordinary.

Accept the fact that she has a lump in her breast as calmly as if

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► Dr. Frank E. Adair, author of this article, has served as president of the American Cancer Society for the past three years. A member of the National Advisory Cancer Council in Washington, he is also associate professor of clinical surgery at the Cornell University Medical College.

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she had a chronic gall bladder or high blood-pressure. At the same time make her aware that she is talking to a sympathetic friend. An attitude of serene confidence (which often calls for some good acting on the doctor's part) will go far toward reassuring the most apprehensive patient. Often it will inspire in her the conviction that she can be cured.

During and after the examination, I am careful to conceal any expression that might indicate to the acutely watchful eye of the patient that I am concerned or shocked by my findings. The examination is made in silence, except for one or two relevant questions. Then I say briskly: "Yes, Mrs. B, you *have* a lump in your breast that doesn't belong there. Just what it is, no one can be absolutely sure until it is taken out and put under the microscope. If it is benign—that is to say, a 'good tumor,'—you will be out of the hospital in a day or two. If it should prove to be a 'bad tumor,' a bigger operation will be necessary and you will have to stay about a week."

I head off the inevitable flood of questions ("Is it cancer, Doctor? Will my breast have to come off?") by maintaining pleasantly but firmly that we cannot be sure until microscopic studies are made at the time of operation.

Even when I am personally certain of a cancer diagnosis, I feel it is good psychology to leave a loophole of uncertainty in the patient's mind. The thought that she *may* have a benign tumor offers her a measure of relief. She feels she has at least a sporting chance of getting off with only a minor operation. She will have a far more peaceful night before the operation, will take a smoother anesthesia, and will be

Peek-a-Boo

While short-handed during the war, I gave hip injections in my office without benefit of draping. Most patients took it in good spirit, but a little spinster well into her sixties was hesistant about lifting her skirt. When she blushed and stammered a request to "put it in my arm," I complied. By her next visit I had completely forgotten the incident. When I again asked her to get ready for the hip injection, she turned pink, but dutifully raised her skirt. To my amazement, there was a round opening, two inches across, neatly buttonholed in her knitted pants.

—M.D., GEORGIA

better able to withstand a radical operation in consequence.

Once it is all over, the tendency is to accept the situation more or less philosophically. This is particularly true when the patient is assured that it was a "bad tumor."

This euphemism, "bad tumor," is as far as I am willing to go with most patients. I think circumstances justify the innocent deception. The word "cancer" strikes such terror in the hearts of most people that to mention it may rob them of all hope and courage. For centuries, "cancer" has been the equivalent of a sentence of death by slow torture. This notion has been fostered and promulgated by old wives' tales and by case histories of friends who have died under harrowing circumstances. Fruitless to try to call attention to the many thousands whose lives have been saved. They are mostly unknown, because a cured cancer patient seldom talks about it.

The husband or some responsible member of the family must, of course, be told the whole truth. But even there I try to soften the blow by dwelling on the hopeful aspects. Sick people are often almost morbidly sensitive to atmosphere. It would be disastrous to the patient's painfully acquired confidence if she suddenly became aware that her family was unusually solicitous or if she intercepted a pitying or despairing look.

About 90 per cent of the patients who come to me say: "Doctor, if I have cancer, I want you to tell me. I can face it." I am too wary to be taken in by this forthright demand. Even among the highly intelligent it is the rare individual who honestly wants the truth. The rest are instinctively seeking reassurance that they do *not* have cancer. It is up to the doctor to differentiate between a genuine desire for truth and pathetic bravado. This sometimes calls for the wisdom of Solomon coupled with the discretion of a career diplomat.

I was recently almost shaken out of my professional composure by a patient who had had a radical mastectomy for a proven carcinoma more than ten years before. She was a clever, attractive woman, and I had always held her intelligence in high esteem. She came in for her annual check-up the other day and during the course of conversation remarked: "Do you know, Doctor, if I had ever thought during those years that I had cancer, I would have gone out and killed myself!" Silently I breathed a prayer of thanksgiving that I had never told her.

On the other hand, I recall a gallant woman who refused point-blank to go ahead with the prescribed treatment unless she knew what the score was. Sensing her genuine sincerity, I told her exactly what she faced. From that moment on, she was 100 per cent cooperative and fought all the way.

There are certain business and professional men to whom one has to state the case frankly and fully. They require time to put their affairs in order and to make provision for their families. Even with them, stress only the practical aspect of such an arrangement. Never shut the door of hope in their faces; never let them feel you have abandoned them or lost interest.

Here are some basic rules that, I feel, cover the psychological approach to nearly all types of cancer patients:

1. Banish fear and its concomitant, despair.

2. Never let your attitude show that you consider the case hopeless.

3. Make the patient realize that there is nothing unusual or disturbing about his case and that he is not earmarked for certain doom.

4. Make the patient feel you are a friend who is there to help not only physically but mentally as well.

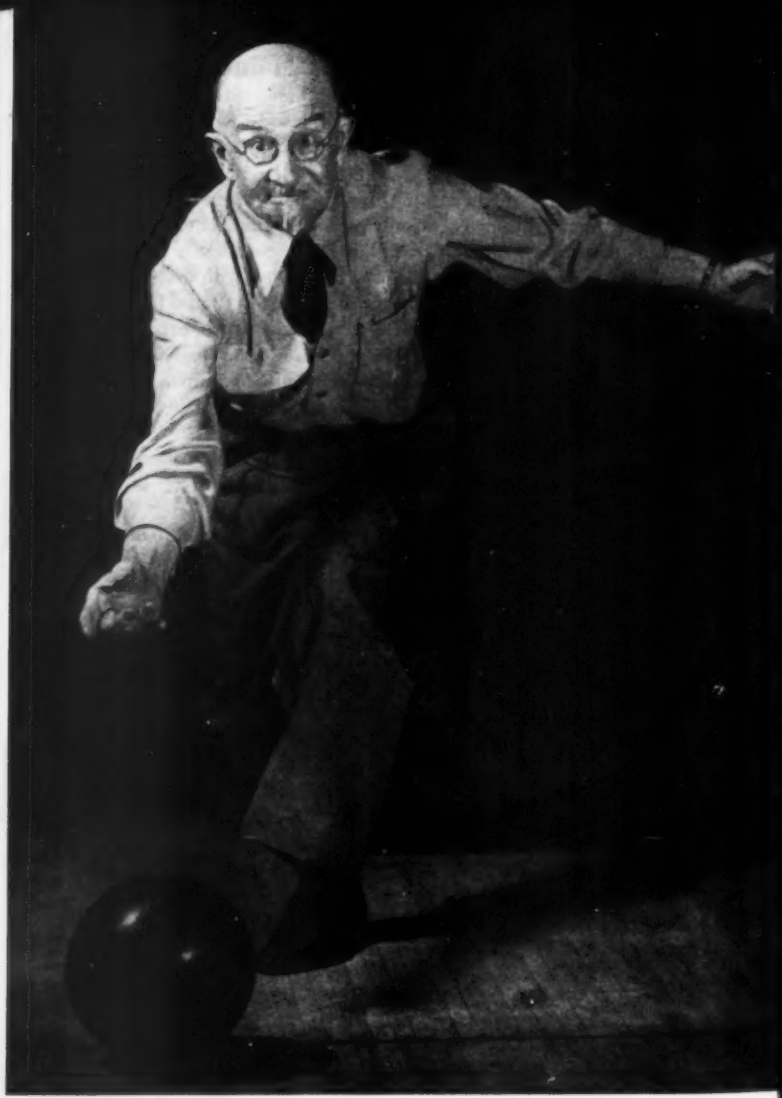
5. Radiate confidence and optimism, even when you are not sure what the next step should be.

6. Avoid the word "cancer" unless you know your patient like a book. Be willing to equivocate or to lie outright if the end justifies the means.

7. Remember that to keep faith alive is a prerequisite to keeping your patient alive.

—FRANK E. ADAIR, M.D.

"THERE'S ROOM FOR YOU NOW, DOCTOR. ONE OF THE VISITORS JUST LEFT."



Ten-pins take a licking, and so does Father Time, when Lew Bremerman lets 'em roll.

KEGLER

Toppling three tons of ten-pins in a day might cause even Charles Atlas to turn in his leopard skin. But a spry California urologist, Lewis Wine Bremerman, sets the kegling world agog annually by doing just that. On each birthday he bowls as many games as he is years old. This year he was 70.

Doctor Bremerman, who cuts an impressive figure on the alleys with his white Vandyke, starts his birthday bowlathons at 12:01 A.M. After knocking off a brisk twenty games, he ducks out for an early-morning round of patients. He's back at 10, when he really hits his stride. In the late afternoon comes a breathless set of hospital rounds, then the final flurry of hardwood. Last year he finished just before midnight. Soon, he figures, his birthday patients may have to come to the bowlatorium for treatment.

A bowler since 1897, Doctor Bremerman thinks the sport is the greatest health conditioner there is. His love for it led him to organize the American Medical Bowling Association. Today it boasts teams in nearly every state. Another pet project is a five-man team of old-timers whose ages add up to 353 years. Sparked by Lew Bremerman, the quintet can bowl the arms off many a younger pin-ball team.

The doctor lives in Santa Monica, bowls year round in Los Angeles, but saves his mightiest effort for his birthday stint. Stoked with four quarts of half-and-half and a dozen "frank-hamburgers," he racks up scores that have averaged as high as 182. Twice he has missed perfect 300's by just two pins. At the end of his latest kegling orgy, the "maple-mauling medico" (as a local paper calls him) reported a badly mutilated thumb. But he could still chortle: "I feel great! How about a slight libation?"

MUSKETEER

At first glance, you might think Dr. Walter R. Stokes a likely candidate for the "Squarest Peg in Roundest Hole" title of World War

Deadeye Walter Stokes reserves a special set of cold shots for his feathered friends.

II. He is a Washington, D. C., psychiatrist who specializes in marriage counseling; but the Army made him boss of its Air Corps weapons school at Las Vegas.

This sounds like a brass-hat blunder rivaling the case of the steam-shovel operator assigned to stenotypy. Actually, the Stokes dossier caused plenty of skull exercise in the Pentagon. After pondering the foxhole applications of marriage counseling, the moguls decided that K-rations and orange blossoms wouldn't mix. Then they ran their fingers down the doctor's record until they came to his after-hours specialty—and scored a bullseye.

Bullseyes, in fact, are Walter Stokes' stock in trade. Seven times he has copped the world championship in heavy-caliber rifle shooting. He has fired on eleven U.S. rifle teams against the cream of inter-

national competition. All eleven have been hands-down winners. The high spot of his career on the firing line came in a nip-and-tuck shoot at Milan, when he edged out a Swiss marksman by a single point to clinch his second world championship. Doctor Stokes still prizes some of his tournament targets today. A typical one looks as if someone had rammed a crowbar through its exact center.

Walter Stokes began squinting down a steel barrel at an age when most kids take up beanshooters. His father ran a hunting lodge in Central Florida. Older patrons recall being mildly alarmed when their shooting parties were turned over to a 12-year-old guide; but even a tyro could see that he was fair enough with a fowling piece. By the time he was 15, he was shooting in big-time competition.

When his family moved to Washington, he found he could make his hobby pay off. He helped finance his schooling by coaching a college rifle team and by matching shots with the best pro sharpshooters in the country. So successful was this formula that he used it to work his way through college, law school, and medical school. He got his LL.B. in 1924 and his M.D. in 1928, both from George Washington University.

His present practice is an unusual blend of gynecology, psychiatry, and law. The premarital medical service he set up a few years ago has catered to more than 2,000 altar-bound couples. Its features: practical instruction in birth control, marriage technique, and family planning, as well as examinations required by varying state laws. So rapidly has his specialty developed that he feels the day of the board diplomate in marriage counseling is foreseeable.

"Marriages made in heaven? Bah!" says the keen-eyed Washingtonian. "Marriages are made by the people who enter into them, and skilled medical advice is their best insurance of success." Most marriage advice today stems from ministers and social workers, he points out. For medicine, he thinks the field is still what might be described as virgin territory.

One of his own favorite bits of advice is: "Plan to have your babies during the spring, when environmental factors are generally more favorable." This has caused repercussions in an unexpected quarter. The doctor admits to "some good-natured griping from obstetric colleagues who complain about their heavy spring work load."

After his wartime surfeit of rifle-ranging, Doctor Stokes shifted his aim from cardboard targets to small game. Though his practice today often keeps him office-bound, periodically he reverts to type. That's when he forgets about his job of fostering family circles long enough to break up a few of them. Duck families, that is.

Weather clear, track fast as Lee Ellis prepares to joust with downtown Baltimore traffic.

BUGGYMAN

He was one of the few physicians who never once peered wistfully at a new-car dealer's priority list. In the seething traffic of downtown Baltimore, you could spot his trim phaeton most any morning. It had full draft ventilation, no-clutch transmission, and a power plant that racked up thirty miles per bale of hay.

A month ago, death came to 79-year-old Alfred Lee Ellis, a horse-and-buggy doctor from the word "whoa." He never owned an automobile and never wanted one (see cover).

In forty-two years, while making his professional rounds, he put 200,000 miles of buggy-riding behind him. What's more, he could still hold his own against such latter-day menaces as women drivers and yellow cabs. Though city traffic brought him many close shaves, he was nicked only once. That was when his hired driver failed to apply enough lead angle to a crossing trolley; the good doctor was fined $1.25 for "reckless driving."

Automobiles simply weren't dignified enough to suit Lee Ellis. He'd been telling that to car salesmen since the days of the Stanley Steamer and, after four decades, they were ready to believe him.

In later years Doctor Ellis, a friendly, slow-moving G.P. with a snow-white fringe on top, always turned over the reins to a hired driver. William was a graduate of six-horse hay wagons and proved adept at maneuvering the doctor's rig. Soon two of the steeds the doctor owned, Lady and Silver, could recognize traffic lights as readily as they recognized two different brands of oats. A third prancer, Starlight, even caught on to the law about stopping five feet from a halted trolley.

Downtown parking was a breeze for this combination, but, just to make it easier, the doctor sported a special police permit (the last of its kind) on the dashboard of his buggy.

Winter driving? "No trouble at all," Lee Ellis used to say. "On the coldest days we keep a lantern under this lap robe"—pointing to a black comforter liberally sprinkled with white horsehair. "Works a lot better than most car heaters that I've seen."

Until his death, Doctor Ellis kept up a schedule that would have fazed many a younger man. All last summer, for example, he had office hours in the early morning, house calls until noon, more office hours in the afternoon and evening. A catnap after lunch helped him keep up the pace.

What helped even more was the horse and buggy. To his way of thinking, long life stemmed from the fresh air and sunshine he absorbed during four decades of rolling in style through Baltimore.

Frozen Assets

A patient I had not seen for many years came to my office quite disturbed. She feared her husband had embarked on extramarital adventure. Since she had had no normal relations with him for nine years, she hardly blamed him; but she was no less upset. In talking with her I discovered that nine years before she had had some pelvic surgery done. Afterwards her surgeon had told her to abstain from physical contact with her husband. Of course he meant until healing was complete, but she misunderstood. Now, incredulous but happy, she left my office, resolved to make up for lost time. —M.D., PENNSYLVANIA

New Public Relations Program Sets Pace for Medical Profession

Scheduled fees, health campaigns, self-regulation stressed

Most any layman can name at least one feature of medical practice today that rubs him the wrong way. Perhaps he doesn't understand how physicians set their fees. Perhaps he has tangled with a fringe practitioner whose standards weren't up to snuff. Perhaps the profession's reserve in dealing with publicity or community affairs has gone against his grain.

These irritants are an old story to most medical men. For years they have hacked away piecemeal at the job of eliminating them. A month ago they got a rare lift from a new source. Colorado physicians had come up with a counter-irritant that might well spread to every other region.

It took the form of a concerted drive aimed at:

¶ Publicizing detailed schedules of the average fees charged by physicians in every part of the state.

¶ Setting up a new board of physicians to check on doctors' ethical and professional standards.

¶ Expanding the profession's role in public health by means of community campaigns spearheaded by M.D.'s.

¶ Improving relations with the press through a liberalized policy on medicine's "No names, please" tradition and through a stepped-up information service.

CLEAN BEAT

The scope and vitality of this program drew whistles of astonishment from as far away as Chicago, where the AMA had been working on its own public relations program for eighteen months. On-the-scene observers were even more enthusiastic. Said James J. Boyle, Washington representative of the United Public Health League, who attended the Colorado State Medical Society session that approved this plan: "The program of public service adopted here cannot be matched by any other state in the nation. I hope it starts a chain reaction that will spread through the country."

The area's leading newspapers bestowed a "Well done, Doctors!" and lauded the fact that the plan was designed "not to protect the personal interests of M.D.'s but to

safeguard the welfare of their patients." Others noted that the Colorado program was shrewdly slanted to bring extra dividends to doctors collectively in the form of superior public relations. As such, it will get plenty of study in coming months from physicians everywhere.

What gave the new plan its impetus? Dr. Bradford Murphey, chairman of the Colorado society's board of trustees, explains: "For several years the officers of this society have noted a gradual but definite deterioration in relations between the medical profession and the public. This decline in public relations became so apparent to the rank and file that our house of delegates, meeting in September 1946, voted almost unanimously for a broad public relations program."

FINGER ON THE PULSE

To finance the bold action they deemed imperative, the physicians hiked their medical society dues for a five-year period. Then they hired a top name in medical public relations, Raymond Rich Associates*, to dredge up the necessary facts.

Six months later they got them. As he had in his 1946 survey for the AMA, Raymond T. Rich set forth plain-spoken findings on why "large numbers of lay persons have become separated in thought and feeling from the medical profession." But this time there was a difference in how the survey results were handled.

First, a copy of Rich's 15,000-word report† was mailed to every doctor in the state. It was annotated to show what action the medical society trustees had taken on each point. Then, throughout the summer, local societies thrashed out the Rich recommendations. Officers of the state association and members of the Rich firm toured the state to explain the report and the actions already taken by the trustees, and to inspire thinking on policies that would require action by the delegates.

By the time the delegates met in September 1947, the rank and file had been well saturated. Twenty-eight of Rich's thirty sweeping recommendations won the doctors' unanimous imprimatur, only one with major changes.

HIT-OR-MISS FEES

According to the survey team, the basic situation confronting medicine was this: "Despite the vast amount of good will toward individual doctors, physicians as a group have become increasingly isolated from the rest of the community."

What had caused the split? For one thing, Rich concluded, medicine's "failure to deal adequately

*Now Raymond Rich & William Cherin Associates.

†"Report on Public Relations to the Colorado State Medical Society." (Excerpts contained in this article are quoted with the permission of the Colorado State Medical Society, which holds the copyright.)

Handitip

Writing Desk

Maybe it was the war-time USO recreation centers that gave me the idea. Their desks with handy stationery used to invite me to write letters. Now I've installed a small desk with writing paper in my reception room. My patients are glad to use their waiting time to pen overdue notes. —M.D., MINNESOTA

with the cost of medical care." Said the report: "The average layman is especially disturbed by what seems to him the arbitrariness of medical costs. When he receives a bill from a doctor, he usually has no way of knowing whether or not he is being charged a fair price . . . He is apt to reach the conclusion that all doctors charge whatever the traffic will bear."

To clear up this confusion, Rich urged prompt publication of minimum fee schedules for each local society "despite the objections that will doubtless exist." Colorado delegates decided it would be better to list *average* fees. Once that change had been made, they threw their weight behind the proposal.

Setting up such fee schedules would be no cinch, the publicist warned. "There is the variation in the cost of living in different parts of Colorado," he pointed out. "There are questions concerning proper differentials in fees between persons of high, moderate, and low incomes. There is the intricate relation between general practitioner and specialist fees.

"But the state medical society has demonstrated that comparative costs for various kinds of medical care can be established. It has done so in a limited field for Colorado Medical Service and, more widely, for medical care of veterans . . . The establishment and publication of fee schedules will largely end the present chaotic system which exposes the entire profession to most damaging criticism."

POLICE WORK NEEDED

One notion widely bandied among laymen, the pulse-feelers discovered, was that "doctors are so clannish they will go to any lengths to protect the unethical colleague." Much of this the report ascribed to mere gossip—but not all.

"No profession relishes police work," wrote Rich. "Yet a certain minimum is necessary to protect its good name. At the very least, membership in organized groups can be refused, after a proper hearing, to any colleague who is patently guilty of malpractice."

The delegates mulled it over, then voted for a brand-new Board of Supervisors to keep tabs on the professional conduct of all medical men in the state. At the same time they issued this directive to their prepay plan's advisory committee: "Investigate every complaint of

overcharging. Present those found guilty with the alternative of withdrawing from participation or reducing their fees."

PUBLIC HEALTH SLATE

What about the profession's role in public health? The analysts put a finger on one specific flaw: "Doctors as a group have devoted a sizable amount of time and energy to getting behind public health measures. But there is little evidence to indicate that they have often been out in front, inspiring other groups and sharing leadership with them." Result: another setback for medicine's public relations.

By way of turning the tide, Colorado physicians blocked out two new tasks for the component medical societies. Each one was to identify the most serious public health problems within its county, then put well-staffed committees to work handling these problems in the order of their importance.

Even before these wheels started to turn, the state society planned five new public health ventures of its own. They were to include a new neuropsychiatric institute, a child guidance center, and programs for civilian rehabilitation, rural health, and industrial medical service.

What accounted for medicine's

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"MEET DR. WARE—THE ONLY MAN ENGAGED IN GROUP PRACTICE BY HIMSELF."

strained relations with the working press, according to Rich, was the "ambivalent attitude" many newshawks attributed to physicians. As one editor put it: "They expect us to publish the correct dope on medical matters, but just about all we ever hear from them are complaints when they don't like a story."

DOCTORS IN THE NEWS

A typical case was cited: that of a reporter preparing a story touching on medicine vs. quackery. Said Rich: "If he is unable to quote a reliable medical source, he may find his copy heavily slanted in favor of the more uninhibited spokesman for quackery."

A Rich recommendation that won M.D. backing called for "a compromise between the requirements of journalism and the traditions of medicine." Under the new policy, the press would be encouraged to quote medical society officers (presumably by name) on matters of public interest. On matters pertaining to private practice, the customary reticence would be maintained.

In other Rich-inspired moves to spread news of medicine faster, Colorado physicians

¶ Set up an augmented information service that would employ news releases, newsletters, radio talks, and seasonal health tips sandwiched in between other network programs.

¶ Provided for a series of open-house meetings that would bring physicians, laymen, and the press together for periodic, hair-down discussions.

¶ Authorized the hiring of a field secretary. While the executive secretary looked after headquarters business, the new man would make the rounds of local societies and lay groups. —R. C. LEWIS

Don't Talk, Chum!

I was operating on a diabetic young woman who had recently married a friend of mine. The operation was a long one, and, after working in silence for some time, I remarked casually to the nurse that "it must have been a shock to the husband when he found he had married a diabetic."

To my great embarrassment, an angry voice retorted: "I'll have you know he knew that before the wedding!" The voice was the patient's. It had slipped my mind that a spinal anesthesia had been used, and that she was awake. —W. H. REED, M.D.

A Check-List of Investment Terms

It's hard to keep tabs on the market unless you speak the language

[EDITOR'S NOTE: For anyone who wants to follow the dollars he has invested, Wall Street lingo is a must. This check-list is the fourth and last of a series that defines the stock market's own peculiar jargon. Its author is Joseph Mindell, an economist for an investment banking firm. He has also written "Guide Posts to Wall Street," published by B. C. Forbes.]

PRICE-EARNINGS RATIO. The market price of a stock divided by its annual earnings per share. A stock that sells at $100 and earns $10 a share sells at ten times earnings.

PROSPECTUS. The detailed description of a new security issue. Under the Securities Act of 1933, a prospectus must be supplied to all prospective buyers.

REFUNDING BOND. A bond issued to pay off an earlier one; usually issued at a lower rate of interest.

REGISTRATION STATEMENT. The form filed by a corporation with the Securities and Exchange Commission in connection with an offering of new securities.

RESISTANCE. Opposition to a rise in a stock's price caused by the availability of enough shares to satisfy all buyers.

RIGHTS. The privilege given stockholders of buying new issues at par or below the market price.

SCALPING. Operating for quick, small profits.

SEASONED ISSUES. Securities that have been known favorably to the investing public over a long period.

SHADING. A falling off in prices.

SHORT SALE. The sale of a stock one does not own, in anticipation of a market decline. The broker borrows stock for the transaction.

SINKING FUND. A reserve established to retire part of a bond or preferred stock issue in advance of its maturity date.

SPECIALIST. The stock exchange member who keeps the "book" in a stock. On the basis of orders from outside and bids on the stock exchange floor, he sets the offer price.

SPLIT-UP. The division of a corporation's capital stock into a larger number of shares. The split-up aims at creating more negotiable lots.

STOCK, COMMON. Ordinary capital stock not sharing the privileges of preferred stock; it represents

equity ownership in the corporation.

STOCK, PREFERRED. Stock that has a prior claim on dividends and on corporation assets.

STOP. An order to buy or sell a stock at the price designated by the stop.

SWITCHING. Exchanging one security for another.

TECHNICAL. Designating a market in which manipulation is largely responsible for prices.

TREND, MAJOR. A broad, basic trend lasting several years.

TREND, INTERMEDIATE. A trend lasting several weeks or months. Such a trend may run counter to the major trend and be correlated with technical conditions.

VOTING TRUST. A small group of stockholders that exercises the voting privilege of a larger number.

WARRANT. A certificate that gives a shareholder or management the right to subscribe to capital stock at a fixed price. It generally extends over a longer period than the ordinary subscription right given to a shareholder.

WHEN ISSUED. A term applied to dealings in proposed securities to be issued under some reorganization, merger, or new capitalization plan.

YIELD. The percentage of return in interest or dividends. A stock selling for $100 that pays a $5.40 dividend yields 5.4 per cent.

—JOSEPH MINDELL

"MY PATIENTS PAY ME OFF IN PRODUCE."

Holding Down Taxes on Capital Gains

Plus some suggestions for making the most of your capital losses

When you get to the section of your Federal income tax return that deals with capital gains and losses, don't give up. It's less complicated than it looks.

The average physician will be affected by that section if (1) he has capital assets such as stocks or bonds, land or buildings; if (2) he has sold them in the past year and realized either a profit or loss. The amount of profit or loss is determined, in most cases, by comparing the selling price of the asset with its purchase price. Your tax is determined by the amount of your profit or loss and by how long you held the asset before selling it. On an asset held for six months or less, you will have a *short-term* gain or loss; on an asset held for more than six months, a *long-term* gain or loss.

DEDUCT CAPITAL LOSSES

For the average physician ($8,000 net income bracket) the tax computation goes like this: Add to your net income 100 per cent of the short-term and 50 per cent of the long-term gain or deduct if there is a loss. Normal and surtax rates apply to the resultant total.

If your transactions resulted in a net capital loss, not more than $1,000 of the loss may be deducted from this year's net income. But any excess may be carried over for five years and applied against capital gains in those future years.

Take, for example, the case of Doctor A who this past year had a net income of $8,000. In August he sold a house he had bought ten years before as an investment; his profit was $2,000. Last month he sold stocks he had bought in June and made $500. Result:

Long-term capital gain (computed at 50%) ..	$1,000
Short-term capital gain (computed at 100%)	500
Net income	8,000
Total taxable income .	$9,500

If Doctor A has lost $2,000 on the sale of the house and has dropped $500 in the stock market, his computation will be quite different:

Long-term capital loss (50%)	$1,000
Short-term capital loss (100%)	500
Net capital loss	$1,500

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He then deducts $1,000 of this net capital loss from his net income of $8,000, paying his normal and surtax on $7,000. The remainder of his capital loss can be deducted on next year's return.

ALTERNATE METHOD

If your net income exceeds $18,000 and if you have only long term gains (or if your short-term losses are less than long-term gains), you can cut your income tax by using an alternate method. It allows you to add 50 per cent of net capital gains to your tax based on ordinary income.

Assume that Doctor B, with a net income of $22,000 after exemptions, has long-term gains of $10,000 as against short-term losses of $1,000. Under the ordinary method of computation he would list

Long-term capital gains (50%)	$5,000
Short-term losses (100%)	1,000
Net capital gain	$4,000
Net income	22,000
Net taxable income	$26,000

Doctor B's normal and surtax will be $10,203.

By the alternate method, he computes his normal and surtax on $22,000 net income, then adds 50 per cent of his net capital gain:

Normal and surtax on $22,000	$7,961
50% of capital gain of $4,000	2,000
Total tax	$9,961

By using the second method, Doctor B has saved $242.

If you have *both* short- and long-term gains, follow this rule: Treat short-term gains as part of your regular net income. Then after you've determined the tax on that, add 25 per cent of your total long-term gains direct to your tax. The result is the total amount you owe.

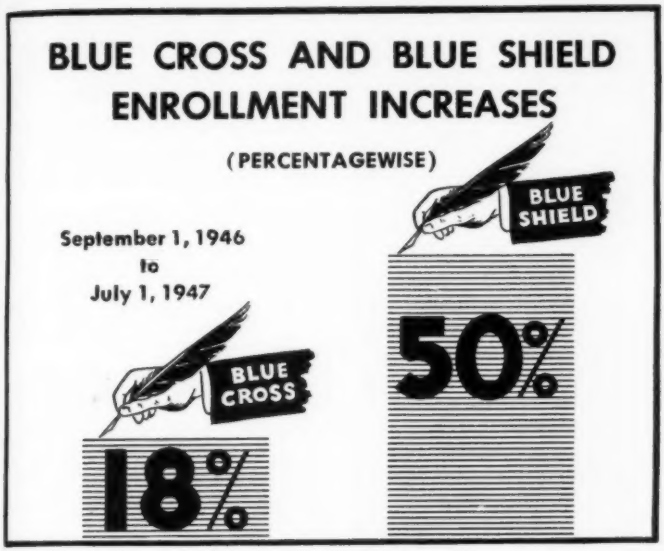
TIME SALES WISELY

For doctors who contemplate the sale of assets in the near future, here is further advice: If you contemplate taking a loss on the sale, sell while you have held the asset for not more than six months. In that way you get 100 per cent deduction for tax purposes. Conversely, if you foresee a gain in your asset sales, hold them for more than six months before selling. Only half the gain will then be taxable. Asset transactions designed to lower your tax are legal as long as they are legitimate sales.

What about sales of real or personal property such as your own house or automobile? If you sell at a profit, your gain is taxable like any other capital gain. But you are allowed no deduction for losses on these sales except to the extent that the property was used for business purposes.

Non-business capital losses are deductible only if you can show that you originally bought the property with the intention of selling it for a profit.

—J. D. OBERRENDER



Medicine's Prepay Plans on Upswing

New study shows broadened coverage and 50% enrollment jump in 10 months

The enrollment curve of medicine's prepayment plans took a sharp bend upward during 1947's first half. As of July 1, medical care plans approved by medical societies covered 6,195,266 persons. This was a 50 per cent increase in ten months.

It meant that medicine's prepay plans were matching the hot pace set earlier by Blue Cross. With a six-year head start, the hospitalization plans had passed the 6 million mark in 1941. By July 1 of this year, Blue Cross enrollment had reached a whopping 28,330,166.

These are the latest figures on voluntary health insurance. They stem from a MEDICAL ECONOMICS study of all medical care plans backed by organized medicine. Here is what the study reveals

about the plans' current scope:

¶ Fifty-seven* prepayment plans approved by medical societies were in full operation on July 1.

¶ People in thirty-seven states (plus Hawaii) could buy medical care coverage from a local, society-sponsored plan. In ten of the remaining eleven states, medical societies were busy setting up plans.

¶ About 110,000 doctors, or more than four-fifths of all privately practicing physicians, were participating.

BLUE RIBBON PLANS

High in subscriber appeal was Michigan Medical Service, nudging the million mark with an enrollment of 932,356. But other physician-backed plans showed signs of catching up:

Fastest growing of the major plans was Massachusetts Medical Service, which added 250,000 new subscribers in ten months. Another comer was California Physicians Service, which signed up 230,000 new customers in less than a year.

Rounding out the first five plans in total enrollment were New York's United Medical Service and the Washington State Medical Bureau, grand-daddy of all medical-society-sponsored plans. Altogether, eighteen plans topped the 100,000 mark in total enrollments (see pp. 68-69).

Though few of them had failed to register gains since the last tally, the medical care plans still had a long row to hoe. Total eligible population has been estimated at 100 million, the number who can afford actuarially adequate premiums. Excluded are about 40 million persons who receive government care.

PLAN DISSECTION

So much for the size and scope of medicine's prepay plans. What about their individual characteristics? Here are some of the more striking details:

¶ A single subscriber pays a premium that averages $1.27 a month. In some regions he can purchase limited coverage for as little as 40 cents a month. In others (and for much more thorough coverage) his monthly premium runs as high as $4.85.

¶ Family coverage costs from $1.38 to $18.50. The average charge for a family of five is $3.34.

¶ The average plan limits its benefits to in-patient surgical, medical, and obstetrical care. It excludes routine home and office calls.

¶ Twenty-eight plans offer a combination contract: cash indemnity for upper income groups, full service for lower. The income limit that divides the two groups runs around $2,700 for a single subscriber, $3,500 for a family. Persons who earn less than the specified limit pay no surcharges to physicians.

¶ Twenty-three plans operate on a straight cash-indemnity basis.

*Washington's twenty county bureaus are counted as a single state-wide plan. Oregon Physicians Service and its four affiliated local plans are likewise counted as one.

The physician is paid according to a prearranged fee schedule. The amount he receives may or may not cover his full fee. If it does not, the patient makes up the difference.

¶ Only six plans offer a full-service contract to all subscribers.

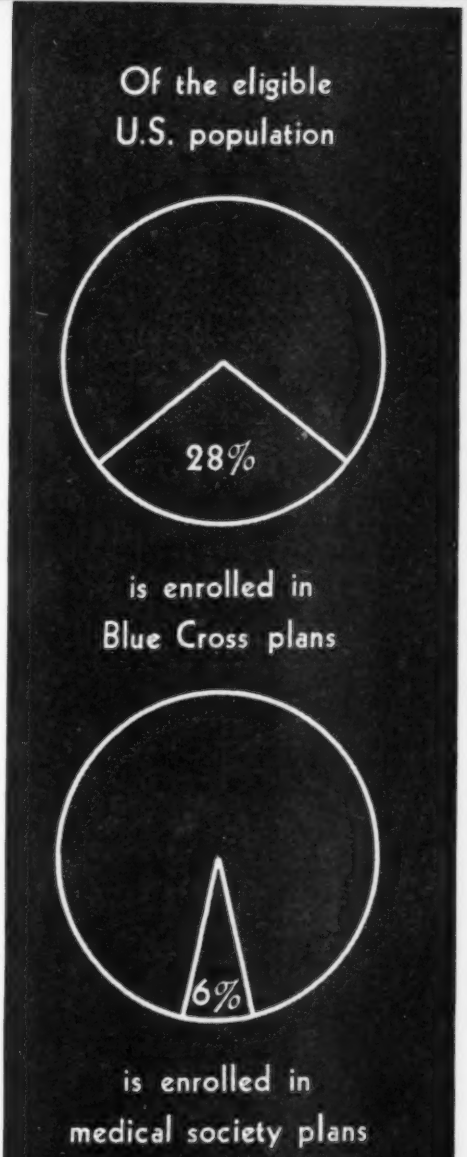
¶ Fee schedules used by the medical care plans vary widely from region to region. The allowance for an appendectomy, for example, ranges from $50 to $150 among the fifty-seven plans.

¶ Thirty-seven of the plans restrict enrollment to employed groups of five or more persons who have already purchased hospitalization insurance. Thirty-nine plans are administered jointly with Blue Cross.

¶ Ten physicians and five laymen make up the governing body of the average medical care plan. The boards of eleven plans have no lay representation. On seven governing bodies, medical men are outnumbered by the laity.

Half a dozen plans offer the most complete health insurance available. They are California Physicians Service, North Idaho Medical Service Bureau, Oregon Physicians Service, South Dakota Injury-Illness Expense Plan, Washington State Medical Bureau, and Hawaii Medical Service Association. Each of these plans offers the "big five" benefits, within specified limits: surgical, medical, and obstetrical care, house calls, and hospitalization.

—MELVIN SCOTT



Fifty-Seven Prepay Plans Approved by Medical Societies

State	Headquarters City	Name of Plan	Type of Plan	Enrollment July 1947	% of M.D.'s in Area Who Participate	Monthly Premiums Single	Family of 5	Benefits*
Ala.	Birmingham	Hospital Serv. Corp. of Ala.	Cash	68,061	100%	$ .75	$2.00	S,M,Ob,H
Ark.	Little Rock	Arkansas Health Plan	Cash	(Started Sept. 1947)	100%	1.60	4.15	S,Ob,H
Calif.	Oakland	Hospital Service of Calif.	Cash	169,377	100%	.60-1.40	2.40- 5.70	S,M,Ob,H
	San Francisco	Calif. Physicians Service	Comb.	508,712	96%	2.00-3.15	6.75- 7.90	S,M,Ob,HC,H
Col.	Denver	Col. Medical Service	Comb.	227,623	90%	.75	1.50- 2.00	S,Ob
Del.	Wilmington	Group Hospital Service	Cash	116,000	95%	.60	1.65	S,Ob
Fla.	Jacksonville	Fla. Medical Serv. Corp.	Comb.	25,197	65%	.80	2.00	S,Ob
Idaho	Lewiston	No. Idaho Med. Serv. Bureau	Comb.	6,000	100%	2.00	6.00	S,M,Ob,HC,H
Ill.	Chicago	The Illinois Plan	Cash	10,000	100%	1.00	3.25	S,M,Ob,HC
Ind.	Indianapolis	Mutual Medical Insurance	Cash	118,046	100%	.75	2.00	S,M,Ob
Iowa	Des Moines	Iowa Medical Service	Comb.	24,392	57%	1.00-1.25	2.50- 3.25	S,M,Ob
Kan.	Topeka	Kan. Physicians Service	Comb.	40,000	95%	.90	2.25	S,M,Ob,H
La.	New Orleans	La. Physicians Service	Comb.	16,517	75%	.85	2.10	S,Ob
Mass.	Boston	Mass. Medical Service	Comb.	656,219	95%	.90	2.25	S,M,Ob
Mich.	Detroit	Mich. Medical Service	Comb.	932,356	75%	.60- .90	2.25- 3.25	S,M,Ob
Mo.	Kansas City	Surgical-Medical Care	Comb.	144,151	96%	.85	2.25	S,M,Ob
	St. Louis	Mo. Medical Service	Cash	88,042	83%	.85	2.25	S,M,Ob
Mont.	Helena	Mont. Physicians Service	Comb.	27,882	95%	1.30	3.90	S,M,Ob
Neb.	Omaha	Neb. Medical Service	Cash	30,196	100%	1.00	2.50	S,M,Ob
Nev.	Reno	Nev. State Med. Assn. Plan	Comb.	3,806	90%	.80	2.80	S,Ob
N. H.	Concord	N.H.-Vt. Physicians Serv.	Cash	123,794	65%	1.40	3.25	S,M Ob,HC
N. J.	Newark	Med.-Surgical Plan of N.J.	Comb.	115,570	90%	.75	2.00	S,M,Ob
N. M.	Albuquerque	N.M. Physicians Service	Comb.	5,134	70%	2.00	5.90	S,M,H,
N. Y.	Albany	Northeastern N.Y. Med. Serv.	Comb.	11,500	89%	1.00	2.25	S,M,Ob
	Buffalo	Western N.Y. Med. Plan	Cash	110,000	95%	.60-1.50	1.70- 3.00	S,M,Ob
	New York	United Medical Service	Comb.	607,688	75%	.40-1.60	1.80- 4.00	S,M,Ob,HC
	Rochester	Genesee Valley Med. Care	Cash	40,017	90%	.60	1.70	S,Ob.
	Syracuse	Central N.Y. Med. Plan	Cash	15,000	85%	.60-1.50	1.70- 3.00	S,M,Ob,HC
	Utica	Medical & Surgical Care	Cash	82,075	90%	.48- .75	1.38- 1.90	S,M,Ob,H
N. C.	Chapel Hill	Hosp. Saving Assn. of N.C.	Comb.	207,704	100%	1.30	2.50	S,Ob,H
	Durham	Hospital Care Assn.	Cash	105,402	100%	1.30	3.00	S,Ob,H

	New York	United Medical Service	Comb.	607,688	75%	.40-1.60	1.80- 4.00	S,M,Ob,HC
	Rochester	Genesee Valley Med. Care	Cash	40,017	90%	.60	1.70	S,Ob.
	Syracuse	Central N.Y. Med. Plan	Cash	15,000	85%	.60-1.50	1.70- 3.00	S,M,Ob,HC
	Utica	Medical & Surgical Care	Cash	82,075	90%	.48- .75	1.38- 1.90	S,M,Ob,H
N. C.	Chapel Hill	Hosp. Saving Assn. of N.C.	Comb.	207,704	100%	1.20	2.50	S,Ob,H
	Durham	Hospital Care Assn.	Cash	105,402	100%	1.30	3.00	S,Ob,H
	Durham	Medical Service Assn.	Cash	60,000	100%	.85	2.00	S,M,Ob,HC
N. D.	Fargo	N.D. Physicians Service	Service	7,900	96%	.75	2.25	S,Ob
Ohio	Columbus	Ohio Medical Indemnity	Cash	230,396	100%	.60	1.90	S,Ob
	Toledo	Community Surg. & Med. Care	Cash	89,365	100%	.85	2.75	S,M,Ob
Okla.	Tulsa	Okla. Physicians Service	Cash	39,228	100%	.75	2.00	S,Ob
Ore.	Portland	Ore. Physicians Service	Service	100,000	90%	2.25-3.00	6.85- 7.60	S,M,Ob,HC,H
Pa.	Harrisburg	Med. Service Assn. of Pa.	Comb.	105,000	60%	.60-1.10	2.00- 3.25	S,M,Ob
S. D.	Sioux Falls	S.D. Injury-Illness Exp.	Cash	2,060	100%	3.00	7.50	S,M,Ob,HC,H
Tex.	Dallas	Dallas County Med. Plan	Comb.	1,813	90%	1.75	3.00	S,M,Ob,HC
	Dallas	Group Med. & Surg. Serv.	Cash	53,802	100%	.75	2.00	S,M,Ob
Utah	Salt Lake City	Medical Service Bureau	Service	23,057	80%	1.00	2.50	S,Ob
Va.	Richmond	Va. Medical Serv. Assn.	Comb.	100,000	80%	.85	2.00	S,M,Ob
	Roanoke	Surgical Care	Service	45,000	95%	.75	1.75	S,Ob
Wash.	Olympia	Wash. State Med. Bureau	Comb.	380,000	85%	2.50-3.75	3.50-10.30	S,M,Ob,HC,H
W. Va.	Charleston	Medical Service	Cash	32,000	82%	.75	2.05	S,M,Ob
	Clarksburg	Medical-Surgical Service	Comb.	5,134	100%	.85	2.20	S,M,Ob,H
	Fairmont	Marion Co. Med. Service	Comb.	13,000	90%	1.60-2.15	3.20- 5.75	S,M,Ob,H
	Huntington	Medical Care	Cash	10,296	65%	1.00	2.00	S,Ob
	Morgantown	Morgantown Med. Surg. Serv.	Comb.	1,304	98%	1.00	2.75	S,M,Ob
	Parkersburg	Medical-Surgical Care	Comb.	15,738	98%	.85	2.00	S,M,Ob,H
	Wheeling	W.Va. Medical Service	Comb.	25,346	98%	.75	1.75	S,Ob
	Williamson	Med. Serv. Assn. of Ky. & W.Va.	Service	5,600	80%	1.50	3.00	S,M,Ob,H
Wis.	Madison	The Wisconsin Plan	Cash	73,000	75%	1.00	5.00	S,Ob,H
	Madison	Wis. Physicians Service	Comb.	10,205	78%	.90	2.50	S,M,Ob
	Milwaukee	Surgical Care	Comb.	109,860	95%	.90	2.50	S,M,Ob
T. H.	Honolulu	Hawaii Med. Service Assn.	Service	19,762	100%	1.25-4.85	5.00-18.50	S,M,Ob,HC,H

*Key To Benefits: S-Surgical, M-Medical, Ob-Maternity, HC-House Calls, H-Hospitalization. Source: MEDICAL ECONOMICS study, July 1947

Should G.P.'s Have a Specialty Board?

It would raise family physicians' prestige, say some; it would hurt medicine, say others

Should general practice be given the status of a specialty? Would an American Board of General Practice be a good thing?

Some family physicians think so. Certification would, they believe, give the G.P. new standing, afford him better posts on hospital and medical school staffs, and open to him new avenues of post-graduate study. Moreover, they say, certification of G.P.'s would discourage so many young medical graduates from specializing.

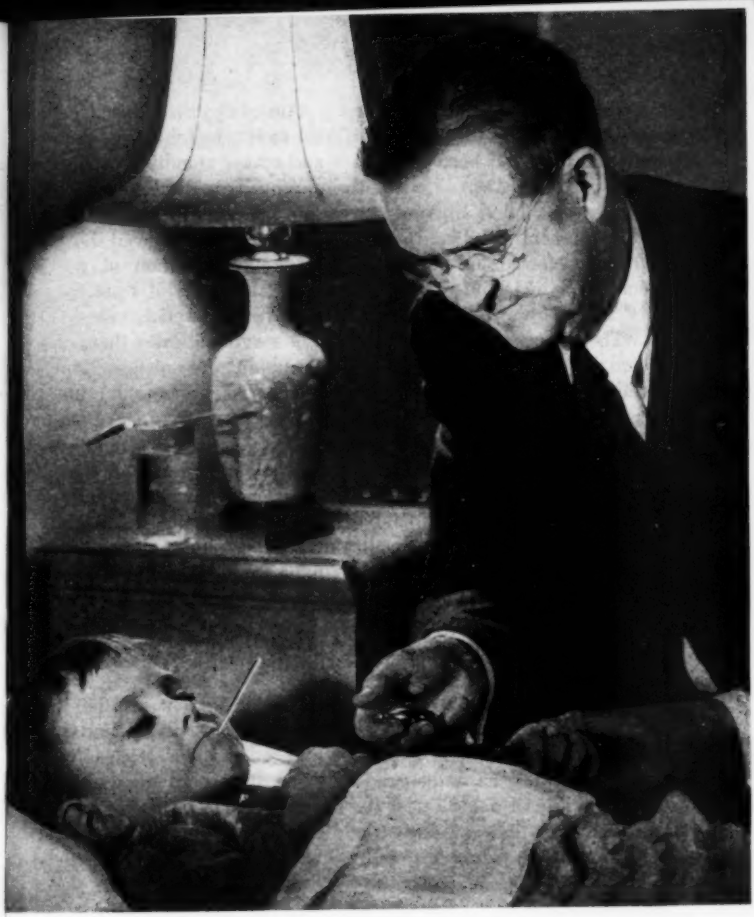
Their attitude has been summed up by Dr. Homer L. Nelms, recent vice-president of the Medical Society of the County of Albany (N.Y.). The competent family physician, Doctor Nelms points out, does post-graduate work, attends scientific meetings, reads his journals, studies his cases, and learns to recognize his own talents and limitations.

"Such a man," says Doctor Nelms, "would be a success in any specialty, for he practices the broadest specialty in medicine. Should an examining board be created, and examinations be properly conducted, only the best could qualify and take their rightful places in public and professional prestige with other recognized specialists."

But other physicians, both G.P.'s and specialists, regard certification as a narrowly conceived device that would do general practice more harm than good. Dr. R. L. Sensenich, AMA president-elect, estimates that some 20,000 G.P.'s out of 120,000 would become diplomates; the rest would, in a sense, become the "untouchables" of medicine. Dr. Wingate M. Johnson, former chairman, AMA Section on General Practice, adds that "To mean anything, such a board should offer a real test of a man's ability. In all probability, some of the specialty boards now existing would be easier to pass than would that of general practice if it were properly conducted."

OSTEOPATHY'S EASIER

As for certification's attracting more medical students to general practice, Dr. W. B. Harm, of Detroit, fears it would actually keep men out of medicine altogether. "Why should any young man take four years of high school, up to



Certification: Would thermometers be too complicated for the non-diplomate G.P.?

our years of pre-med, four years
f medicine, and a year's interne-
hip, only to be told that he has
o take an additional board exami-
ation to sew up a simple laceration
r medicate a running nose? It would be easier to be an osteopath and do as you please."

While the question of G.P. certification has been hotly debated at some medical society meetings, not much official attention has been

given to it. This is especially true among national organizations. For some years there has been sporadic pressure on the AMA House of Delegates to sanction an American Board for General Practice. In 1944 the house referred an unadopted resolution on the issue to the Advisory Board for Medical Specialties. The advisory board sidestepped the resolution, saying that its function is not to create new specialty boards but to pass on applications from groups of physicians seeking to establish them.

In 1941 the Congress on Medical Education and Licensure appointed a special committee to study the feasibility of using the National Board of Medical Examiners as a certifying body for general practice. The project collapsed during the war and has not been revived.

AMONG THE STATES

A number of state societies, however, are keeping tabs on the certification activities in Indiana. In 1945 the house of delegates of the Indiana State Medical Association voted to establish a board to certify general practitioners. The following year the Indiana Board of General Practice of Medicine, Inc., was organized with its own officers. It accepted 185 founder-members without examination. It now offers certification to G.P.'s who can meet its requirements. As a preliminary, candidates present evidence of the following general qualifications:

American citizenship; local medical society membership; high moral and ethical standing; training in an approved medical school; internship, preferably of the rotating type, in an approved hospital; a continuing program of post-graduate education; at least five years in general practice.

A candidate must then:

Submit, for review, reports of twenty-five cases under his care.

Pass a written examination on basic sciences and general practice.

Pass an oral test of his clinical experience, his adaptability to general practice, his understanding of the patient as a whole, and his familiarity with recent medical developments.

Pass an observation test of his ability at the bedside and in the laboratory.

In its first year, the Indiana board has examined and certified nine candidates. It does not consider this record particularly significant. But a year's experience has pointed up the board's biggest job: to help provide refresher and post-graduate education.

What the future holds is anybody's guess. The creation of more general practice sections in medical societies and hospitals may quiet present talk about G.P. certification. Or such talk may die of its own accord. There is little evidence that most family physicians want an American Board of General Practice. —ROGER HARBURG

Filing a Claim Against an Estate

State laws vary but it's well to know the general routine

When a patient dies, who will pay the physician? A bill owed by an estate is quite likely to become enmeshed in the technicalities of legal administration; and unless the doctor understands and heeds those technicalities, he may never be paid at all.

Of course, when surviving relatives pay the bill out of their own pockets, no problem arises. But if, as often happens, the physician has to look to the deceased's estate for his money, his claim must be presented in accordance with the terms of the law. When the bill is small, some doctors may prefer to take the loss rather than become involved in legal processes. But pressing a claim is usually rather simple.

Ordinarily, an estate is administered in the state in which the patient had his home, not in the state in which he died. Each state has its own law with respect to the form in which claims must be presented. In some states a simple, informal voucher is sufficient; in others a claim will not be recognized unless presented on a special form.

Quite often the executor of the estate or the court in the county where the estate is being administered will supply printed forms to doctors and other creditors on which to draw up their claims.

Complete and accurate records are especially valuable when filing a claim against an estate. It is quite possible that the doctor may be called upon to prove his bill, item by item.

In some states the claim has to be presented to an executor or to an administrator; in others, it must be filed with the probate court, surrogate, registrar of wills, or clerk of the court. The name of the proper agency or official may generally be obtained at the county seat of the county in which the estate of the deceased is being administered.

Most important from the standpoint of the physician trying to collect his bill is the time limit set by each state for presenting claims. In some states a period of only two months is allowed. The purpose of laws that establish time limits for filing claims is of course to enable estates to be settled as promptly as possible.

—CHARLES ROSENBERG JR., LL.B.

Let Your Medical Society Help You

An executive secretary tells you how to get more value for your dues

The secretary wasted another match trying to light his pipe, then said, "I admit that some of our members don't get their money's worth for their society dues. But that's their fault, not ours."

The interviewer was curious. "I don't follow you entirely," he said. "Just what can a county society do for its rank-and-file?"

"That's a fair question," the secretary replied, "and here's the answer: The society can do five things for the member, provided, of course, that he lets us.

"First, we can provide contacts with other M.D.'s and, through ethical society channels, with influential members of the public. These are real practice-building activities.

"Second, the society can protect the member's practice as well as help build it. An immediate example of this is the favorable malpractice insurance rate available. The cash saving in this item alone often exceeds the dues. The society also protects the member's practice by helping to erect legislative barricades against invasion by cultists and substandard practitioners.

"Third, the society is always ready to give advice and assistance on vexing ethical questions. If a member asks our counsel before taking some doubtful step, he receives a guide to the proprieties that may save him great embarrassment.

"Fourth, we're a social organization, a source of friendships and pleasant companionship for the doctors and, through the auxiliary, for the families.

"Finally, the society is an educational agency. Our meetings are miniature graduate courses. If a member attends regularly, he is bound to pack in a lot of medical information in the course of each year."

True, agreed the interviewer, the society provides these aids and the alert practitioner takes advantage of them. But many members still have grievances.

"Grievances!" snorted the secretary. "Listen. Most gripes against the society are aired in hospital cloak rooms, in the lobby of our meeting hall, in the restaurant we go to after sessions. If the complaining members were to stand up

at business meetings and air their protests, we'd have a chance to correct the defects. We can't do anything about whispered gripes and voices from offstage.

"Some members say, 'What's the use? The society is run by a clique.' Yet the truth is that we need officer material. Any member can tell the president that he wants to serve on a certain committee. We get so few volunteers for these jobs that the president is pleased as punch to place a man who really wants to work. It's unfair for anyone to say he's excluded unless he's made a real effort to participate.

"I've heard members say that dues are too high. I have yet to see one of the complainants examine the budget and point out where he thought we could make a saving. The budget is published; any member can fine-comb it to his heart's content. But it's easier to complain than to offer a good suggestion.

"And *we've* got some gripes, too. We spend nights sweating out a practice-building plan for members. We have three functioning right now. One is a home-town plan for the care of veterans. Another is a project whereby M.D.'s get paid for taking care of indigents. A third is our voluntary health insurance plan. These programs pour thousands of dollars annually into the pockets of our members. The doctors are glad to receive the checks, but they sometimes balk at filling out the forms or complying with the administrative details essential to such plans. Then they complain if the program doesn't roll in high gear.

"A member will scream that he has not been getting his journal. It may be his own fault because he never told us he had changed his address.

"In the past year three of our men got into ethical difficulties. One thoughtlessly agreed to serve as consultant to an osteopathic institution. Another got involved in a malpractice action when he could have protected himself by consulting us beforehand. A newcomer to the county, unfamiliar with local customs, ran into embarrassment because he announced in a newspaper that he had become a board diplomate. All these members ran to us for help. And we managed to get them out of their troubles. But how much better if they had made intelligent use of our facilities first!

"Then there are the doctors who

Handitip

Write Light

Those midnight messages that you write in the dark and then can't read in the light won't frustrate you once you've gotten a new flash-pad. It has a pencil connected to it that flashes a light when you pick it up.

accept committee appointments, never show up at meetings, and deride the committee's work. And those who forget to pay dues and become indignant when they forfeit membership privileges.

"Yes, a doctor can get a lot out of his society, but he has to do something himself, too."

The interviewer pointed out that some members felt the society could have shown more energy in getting them hospital appointments or office space.

The secretary shook his head. "There are certain things we cannot do. If cultists are permitted to practice by state law, we can't stop them. If office space isn't available, we can't find it. By the same token, we can't persuade a hospital to put a doctor on its staff. Nor can we order General Motors or Ford to release a new car to one of our physicians. If a nonmember misbehaves, we cannot possibly discipline him, though the law might. Too many men apparently expect us to do things for them that are utterly beyond our power.

"When I say the organization is behind the doctor, working all the time for his benefit, I sometimes get a skeptical 'Oh, sure.' But it's true. We spent all last week-end with the state welfare department, for example, persuading them to raise fees for doctors who care for indigents. A week ago a committee sweated for hours with a few state senators to block a bill that would have opened the doors to substandard practitioners. We do work like this month in and month out.

"The doctor who will inform himself of our resources and policies, come to meetings, volunteer to work with us, and participate in our activities is always welcome. He's the man who will really get his money's worth out of his dues, not only in the sense of practice-protection and practice-building, but also in terms of education, companionship, and personal satisfaction."

—ALTON S. COLE

Coffin Spasm

One of the patients admitted to my influenzal pneumonia ward at the base hospital was a colored corporal named Sam Johnson. We telegraphed his mother that he was seriously ill, but assured her he would get all possible attention. Next day Corporal Johnson received this telegram from his mother: "Let me know how you are getting along. If you die, have body shipped home."

—M.D., PENNSYLVANIA

Changes Seen in Medical Schooling

Students getting more public health, military, and atomic medicine

Undergraduate medical training is being revised drastically to fit the changing needs of our age. Shifts in emphasis based on wartime advances in medical knowledge have been noted in all branches of medicine. These changes, emerging now as a clear trend, are being incorporated into medical school programs from coast to coast.

More new aspects of medicine will be stressed during the next few years than at any time in the past. To get a cross-section of viewpoints on where the emphasis will probably be placed, men in many branches of medicine have been queried. The views presented here include those of general practitioners, specialists, educators, and hospital administrators.

Nearly all agree that stronger accent will be placed on public health training. Often subordinated in the past, this field will attain new importance in the next few years. War experiences showed new ways to preserve the health of large masses of people. Results of those lessons will be used in medical schools.

Great educational emphasis on neuropsychiatric problems is in prospect. Today's medical school training deals largely with organic factors. Tomorrow's will include more psychosomatic medicine.

The war disabled thousands of men who now need treatment. New stress is thus being placed on orthopedics and on physical medicine. At least one medical school has recently organized a new department of rehabilitation; others are contemplated. Quite a few men who were responsible for wartime rehabilitation advances have accepted positions with leading medical schools and hospitals. Their impact on the teaching of medicine will be unmistakable.

An educational shift toward greater specialization is also likely. Prior to the war, medical schools trained students to be general practitioners. Now a strong trend is noted toward

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► The author of this article is Benjamin Fine, Ph.D., education editor of the New York Times. A Pulitzer Prize-winner, Mr. Fine has also written "A Giant of the Press" and "Democratic Education."

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earlier specialization. Many medical men say the high qualifications required by the various specialty boards have made this inevitable, but not all consider it desirable.

Greater emphasis will be put on the study of antibiotics, of immunology, and of endocrinology.

Military medicine will assume greater importance in medical schools than at any previous time. Says one observer: "A consciousness of obligation to national service must be brought home to all undergraduate medical students if we are to prepare them for the possibility of future conflict."

Because of the bombing of Hiroshima, considerable attention will be given to atomic medicine. Says another source: "Undergraduates from now on should get thorough instruction in nuclear physics. They must learn all that is known about cellular and constitutional changes resulting from atomic radiation."

Medical training is reverting quickly from its accelerated, wartime status to the normal, four-year course. Among most educators and hospital authorities there is conviction that the normal development of a topflight doctor requires four years of undergraduate study.

If medicine is to discharge its obligation to society, it must change its teaching techniques to keep pace with the times. Its schools appear to be accepting that challenge. —BENJAMIN FINE, PH.D.

V.A. Medical Funds Won't Stretch, Home-Town Plans Feel Pinch

Hospital building program also hit by shrinking dollars

Millions of Americans a month ago were reading an ecstatic Reader's Digest article entitled, "Veterans' Medicine: Second to None." It detailed the phoenix-like rise of the V.A. medical department from the ashes of the Frank Hines regime.

But the V.A.'s top physicians didn't have time to bask in the glow. They were up against one more critical problem: How to continue their topflight program in the face of a none-too-generous Congressional appropriation and a spiraling inflation that was playing havoc with their cash on hand.

For one thing, the outpatient service division, which operates V.A. clinics and the home-town medical care program, was about $70 million shy of its needs. That unhappy situation had developed thus: (1) Regional directors had underestimated their requirements for 1947-48; (2) Dr. J. C. Harding, assistant medical director of the V.A., had corrected the deficiencies in a more realistic budget; and (3) Congress had chosen to take the regional figures.

On top of that, the dental program* had soared beyond anyone's expectation. Last month it was using up 60 per cent of the funds earmarked for all outpatient work, leaving only 40 per cent for medical care.

TAUT PURSE-STRINGS

All the signs pointed to economy and more economy in outpatient work. Regional directors were trying to keep home-town cases to a minimum and to utilize V.A. clinics wherever possible. Physicians in the more populous areas felt the pinch most. In New York City, for instance, the V.A. regional director declared that no authorizations for private care would be given unless (a) the veteran lived so far from a clinic that it would mean physical hardship for him to get there; (b) he suffered from a physical condition that would be affected by such travel; or (c) he could prove that such travel would make him lose considerable time from work.

[PLEASE TURN TO PAGE 80]

*Dental care is given eligible veterans through clinics in V.A. hospitals, regional offices, and in some subregional offices. A home-town dental program also operates in all forty-eight states and the District of Columbia.

Renegotiation of home-town-plan fee schedules continued last month at a snail's pace. Less than a dozen state medical societies had submitted revised schedules that were acceptable to the V.A. But the V.A. had withdrawn its threat to "lapse" any home-town plan if an impasse were reached. While negotiations continued, existing contracts would be honored—at least until June 30, 1948.

V.A. administrators had hoped to have the whole matter settled by fall. Last month they conceded they had given doctors too little time to work out fee compromises. Doctor Harding said he was "optimistic enough" to hope that renegotiation would be completed by January.

FEE CEILING

The administration was standing pat on the "national format" that placed a "suggested" ceiling on specific fees paid private physicians. A few societies—mainly those in poorer states—liked the format because it tended to increase their fees. In more prosperous regions, physicians took a dim view of what seemed to them a "national fee schedule." But when Massachusetts recently became the fortieth state to inaugurate a home-town medical care plan, the V.A. format was part and parcel of its contract.

Some Congressmen continued to protest that the format was raising all medical fees in their areas. One of them told Doctor Harding: "It's one thing to give a veteran access to his family doctor. It's something else again to make him pay for that convenience in the form of higher fees for his family."

So the V.A. prepared a new stipulation: In states where the format tended to increase fees, physicians would be required to certify, on each billing to the V.A., that the fees charged did not exceed those charged private patients. (One or two regional directors, on their own initiative, had been requiring such certification for some time.)

SPECIALISTS RAPPED

The principal difficulty in settling on new fee schedules for home-town care stems from dealings with specialists, says Doctor Harding. "There is little objection to Part I of the format, which covers ordinary home and office visits. The hitch comes when we try to get agreement on Part II, which is an exhaustive list of surgical and special procedures. Of course, this is the kind of work V.A. hospitals are equipped to do. Only about one case in twenty is farmed out to private specialists. Even so, we can't be put in the position of endorsing specialist fees out of line with those charged the average patient."

Having clamped a $6,000 annual ceiling on fees paid to any one private physician, the V.A. has ordered its regional directors to make exceptions only (1) in areas where a physician shortage or a lack of

V.A. clinics makes the ceiling impracticable; and (2) in cases where a physician has not completed treatment of a veteran.

Why the ceiling? "We had to apply it," says Doctor Harding, "because a number of men were devoting practically all their time to V.A. work and earning $18,000 or more a year in fees.

"That certainly wasn't fair to the men who joined the V.A. on a full-time, salaried basis; they can't earn anything near that amount. And to some Congressional committees, it seemed just a method for bypassing the V.A.'s statutory salary limitation."

PLANS RESHUFFLED

The dollar-shrinkage that plagues home-town medical care plans has also hit V.A. hospitals. The V.A. is currently operating 124 hospitals, one-fifth of them surplus structures taken over from the armed forces. But of ninety permanent hospitals yet to be built, contracts have been let for only eight.

Says Gen. Omar N. Bradley, top V.A. administrator: "A hospital that cost 85 cents per cubic foot in 1945 would cost the taxpayers about $1.80 per cubic foot at today's excessive prices. However, we shall not trim costs at the expense of patient care."

Despite its monetary woes, the V.A. is still doing a land-office business. Last month it took a close look at its medical program and reported these highlights:

¶ Its medical staff comprised 3,630 full-time physicians and 2,536 part-time or fee-basis doctors.

¶ Its outpatient service was examining 175,000 veterans a month, treating 154,000.

¶ V.A. hospitals were discharging 40 per cent of all patients each month, compared with the pre-Bradley rate of 28 per cent.

—ROBERT M. HARLOW

Debtor for Hire

My secretarial assignment from the business school was with a doctor who had removed my tonsils some months before. I was pleased and looked forward to an agreeable working arrangement, but the doctor greeted me coolly. I attributed his attitude to slippery tonsils and tried to make the best of it. But as the day wore on the chill persisted. It was not until I talked on the phone with my mother that the light filtered through. "Oh, my dear," she said, "Dad probably forgot about the doctor's bill and hasn't sent a check yet!" —OFFICE AIDE, NEW JERSEY

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German Health Insurance Seen as 'Assembly-Line Medicine'

System alienated both M.D.'s and patients, says observer

"When compulsory health insurance started in Germany, the beginnings were small. Nobody was aware of its expansionist trend. German physicians were completely oblivious of the fact that a revolution in medical economics had begun."

One man who had a ringside seat for that "revolution" was Walter Sulzbach, Ph.D. As a sociology professor at the University of Frankfurt, he watched state medicine grow into a bureaucratic giant that only the pre-Hitler depression could stunt. Last month, in a newly published monograph*, Mr. Sulzbach summed up his most striking impressions.

Chief among them:

¶ Conflicts over the mechanics of the plan plagued physicians from 1883 to 1933. Doctors had to battle constantly—and not always successfully—to maintain independence.

¶ It is not compulsory health insurance as such that affects the medical profession, but the percentage of the population covered. When less than one-third the people are included and when those of average means are excluded, "there is no reason why doctors should be dissatisfied."

How did German physicians react to the first sickness legislation? The Sulzbach study finds that "the medical profession was not even consulted when the bills were in the making and apparently did not care to be consulted." But doctors were no longer oblivious when they were later hired by sickness fund administrators and told what patients to care for. Both the medical profession and the insured patients bridled at the lack of free choice, Mr. Sulzbach reports.

STRIKE THREAT WORKS

The conflict became bitter when no agreement could be reached on fees. In 1913, says the sociologist, "the doctors threatened to go on strike against the system and to discontinue treatment of any insured person" unless he came as a private patient. This action forced plan administrators to permit free choice of doctors. Fee payment on a capi-

*"German Experience with Social Insurance," by Walter Sulzbach. 134 pages. National Industrial Conference Board, New York. $1.

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tation basis was then arranged.

The study shows that in 1928, peak year of the program, gross earnings of the sickness fund doctor averaged 11,000 Reichsmarks, or about $2,620. At that time 80 per cent of all German physicians were included in the program. Government paychecks accounted for 50 to 60 per cent of the medical profession's total earnings.

Physicians had to battle to keep the side income they received from private patients. "When the Government proposed to extend the system to include higher income brackets," writes Mr. Sulzbach, "the doctors resisted. Each such extension meant the loss of private patients who were able to pay for private treatment." And only by preserving their private practice, says the report, were German physicians able to maintain independence.

QUANTITY COUNTS

Another poser under compulsory health insurance, notes the Sulzbach monograph, is the physicians' attitude toward insured patients. In private practice, the author points out, doctors who earn the best professional reputations usually get the best-paying patients. Under state medicine, "doctors are more interested in the quantity than in the quality of their patients."

In Germany, the sociologist found, physicians who were lenient and ready to attest that a patient was sick were the most popular. And since payment was on a per capita basis, the overworked doctor reduced not the number of his patients but the time spent with each.

Result? "Patients of the German health insurance plan were rarely satisfied with the medical care they received. There was little personal contact between them and their doctors. It was a system of mass treatment in which many doctors spent only a few minutes on each visitor during office hours and made home visits as short as possible.

"*Kassenarzt,* meaning sickness fund doctor, was not a complimentary term. *Kassenlowe* (sickness fund lion), a term used to describe doctors who made big money from a huge number of insurance patients, was even less complimentary. The sickness fund patients were convinced that doctors were more interested in private patients than in them. And in this they were probably correct."

MALINGERING SOARS

More serious than the insults hurled at doctors was the malingering that developed. "Over a period of fifty years in which medical science scored one triumph after another," notes Mr. Sulzbach, "it took the average insurance patient longer and longer to recover." In 1885, according to the report, there were 5.97 days of sickness per member. By 1930 the figure was 11.63 days.

The remedy that cured malinger-

ing was simple. When each member was charged a small fee for his visits to the doctor, Mr. Sulzbach reports, the number of illnesses dropped almost 30 per cent.

No such simple solution is reported for the expanding bureaucracy of Germany's program. In 1931, according to Professor Sulzbach, about 72,000 people took part in medical insurance activities: 37,000 employes and 35,000 doctors. Another 140,000 honorary officials advised the various boards.

This administrative superstructure took its toll in steadily rising costs. "Whatever merits compulsory health insurance had in Germany," says the report, "it is open to question whether it was cheap."

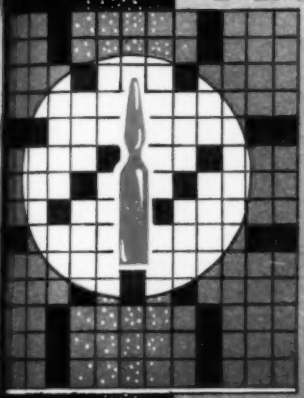
But did the program have merits? Professor Sulzbach hedges. He notes that the infant mortality rate of Germany under state medicine was no lower than that of Sweden, Denmark, or the United States. Nor was Germany's general death rate lower.

"Supporters of compulsory health insurance pointed out that it provided medical treatment and sickness benefits to millions of poor people who needed them," says the Sulzbach report. "The critics emphasized that it provided treatment and benefits to millions of poor people who did not need them."

Did compulsory health insurance help the physicians? Under the specific conditions of between-wars Germany, Professor Sulzbach thinks it did: "The medical profession was better off with social insurance than it would have been without it." Only with state aid, the author concludes, could Germany's impoverished lower classes have met their medical bills at all. The advantage, in other words, was relative. —HAROLD STIEGLITZ

The puzzling

PREMENOPAUSE



The premenopausal years—the late thirties and early forties—are often marred by many symptoms resembling those of the true climacteric. The origin of these symptoms may be obscure, however, because a history of changed menses or "hot flashes" is lacking. In such instances, a therapeutic test with a potent injectable estrogen aids in diagnosis by differentiating between hormonal imbalance and other causes. It is essential, of course, that the estrogen chosen be one which always produces unequivocal improvement whenever estrogen deficit exists.

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1. Brougher, J. C.: West. J. Surg., Obst. and Gyn., *52*:520, 1944.
2. Anderson, H. E.: Local Applications of Vitamins A and D to Nipples of Postpartum Breast, read at meeting of Omaha Mid-West Clin. Soc., 1942.
3. Weissberg, R. S.: Soviet Med., *4*:28, 1940.
4. Kunz, A. C.: Cited by Gunther, M.: Lancet, *2*:590, 1945.

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We Formed a Clinical Club

How a group of specialists keeps the G.P. in them alive

Can a specialist keep up with a G.P. in his grasp of general medicine?

Several years ago this question bothered me considerably. I had been specializing in radiology for some time and could feel my knowledge of general medicine slipping. Attendance at medical meetings and a modest volume of reading helped, it's true. But I knew my outlook would continue to narrow if I didn't do something about it.

Surmising that others might have run up against the same trouble, I invited five friends, all specialists, to lunch. We could, I thought, talk the situation over; perhaps some workable ideas would come of it.

Results exceeded my hopes. From this informal get-together came plans for a program that would *compel* us to keep abreast of general progress in medicine. Each of us invited a colleague to join and the twelve formed the Phoenix Clinical Club.

What we had in mind was a once-a-week luncheon to be followed by informal discussion of clinical cases. We arranged for a caterer to serve meals in a private room. Then we dealt out selected cases from the Massachusetts General Hospital file, assigned a couple of men to work up independent diagnostic discussions, and sat back to see what would happen.

One of *my* first assignments was to diagnose a case presenting symptoms of intracranial lesion. Hemianopsia was one symptom mentioned in the record. Twenty years' accumulation of rust covered any information I might once have had about this; I even had to look up the meaning of the word. Nevertheless, with the aid of some books on anatomy and physiology, I found I could still diagnose brain tumor and localize it from the symptoms.

All this required hours of work, but it gave me a greater thrill than had I fallen back on my own spe-

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▶ W. Warner Watkins, M.D., is chairman of the clinical club he describes here. He served formerly as president of his county medical society, the Arizona State Medical Association, and the Southwestern Medical Association.

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cialty as a topic. More important, I had broadened my viewpoint.

As club enthusiasm and membership mounted, we made our weekly meetings competitive. We formed four groups. One physician from each had to present a previously prepared, ten-minute diagnostic discussion, of the case of the week. Comments from other members followed. Finally, the three judges revealed the post-mortem findings or other pathological proof that showed who was right and who was wrong.

TEAMWORK

In keeping with our aim to widen the specialist's scope, members today routinely discuss cases outside their own fields. Thus, medical problems are assigned to surgeons, surgical problems to internists. The ophthalmologist may discuss a gynecological condition; the dermatologist, a brain tumor. Since each speaker is talking the other men's language, he must know his subject thoroughly.

Judges score each M.D. on his presentation. The winning group rates a banquet at the end of the year, paid for by the also-rans. The three top point-scorers are made judges for the next year's meetings. Last year the best scores were racked up by a chest specialist, an industrial medical referee, and a G.P. from a small town outside Phoenix.

Our programs deal mainly with general medical problems. These are, as a rule, diagnostic. But therapeutic and research studies are included when they seem to add interest.

We closed up shop during the war years, but came back stronger than ever in 1945. Several meetings were devoted to military experiences of members. Last year we split into two groups, "Army" and "Navy." The latter group was forced to pay up at the end of the year.

Our season now extends over thirty weeks. Speakers come in alphabetical order, three at each session. Organization is simple. We have a chairman to control discussions and a secretary-treasurer to keep our simple records.

A pay-in-advance scheme has helped attendance. Members pay $50 for a year's luncheons. Knowing that they're entitled to a meal already paid for, most of them show up regularly every Monday.

Membership today in the Phoenix Clinical Club is strictly limited and rather generally sought after. Five of the original twelve members are still active, and we value the affiliation highly. The club's ranks now include nine internists, five G.P.'s, four general surgeons, two orthopedic surgeons, two chest specialists, and one specialist each in ophthalmology, gastro-enterology, dermatology, industrial medicine, neurology, radiology, and pathology.

—W. WARNER WATKINS, M.D.

How I Got Into Group Practice

What one man learned when he began to expand his solo practice

Twenty patients jammed the waiting room. Ten packed the hallway. Four nurses flew in circles.

A colleague of mine, visiting this medical mardi gras, questioned the physician who ran it: "Can you use my services as an assistant?" "Oh, no," said his host, "I have an assistant already."

I used to run an office like that. But no more. With about the same capital outlay I would have spent for normal expansion, I've started a small medical group.

It began a decade ago when my fifteen-year-old solo practice began to get too large for me. I needed an assistant. In choosing him I made my first mistake.

I found a resident who was willing to become my assistant at $70 a week. But after three months I found his work unsatisfactory and we parted. In the five years that followed I paid up to $100 a week for a variety of M.D.-assistants, none of whom stayed long.

Finally I decided to make one more attempt. There was a possibility of my being called into the service and I hated to give up the practice I had established. An assistant who could carry on without me seemed the only solution.

I tried to analyze my previous failures. In doing so, it occurred to me that all my assistants had been recent hospital graduates. They had thought of our association only as another step in their medical education. They did not take their work seriously enough. They considered the patients impersonally, as belonging to someone else. Thus they contributed little toward the growth of the practice.

I realized that an acceptable coworker would have to be convinced that our association would be lasting. He would have to be assured an adequate starting income and a fair share of the increment as the practice grew.

About that time I met a young M.D. who had ability, personality,

[PLEASE TURN TO PAGE 100]

► The author of this article is a general practitioner whose special interest is cancer. Because income statistics are included here, his name is withheld.

and a record of excellent training. Rejected from military service for a physical disability, he was considering opening an office in my community. He asked my advice; I encouraged him; but I suggested also that he associate with me.

I offered what I considered liberal terms: 20 per cent of the gross and a stipulation that if I were inducted into service, he would receive 50 per cent. I was averaging $3,000 a month, which meant $600 a month for him at the start. Except for his car, he was to have no professional expense.

He would be expected, in return, to give as much service as if the practice were his own. He was to make outside calls I would turn over to him. He would see patients during office hours either with me or, in my absence, alone. The first year he would receive two weeks' vacation with pay; the second year, three weeks'.

He accepted and entered wholeheartedly into the venture. I turned over a substantial part of the work to him. Some patients resented this; some were even disagreeable about it. But my assistant accepted it all calmly and with good grace.

A short time later I was called up for induction but rejected for physical reasons. That was the first work-up I'd had in some time. It made me realize my limitations. I found consolation in having an associate who could assume a good share of my responsibility.

In the next three years, our practice grew steadily. Still we found time for vacations, for occasional week-ends away, and for postgraduate study. Our gross increased to the point where my assistant was netting about $900 a month.

One day he introduced me to a young colleague who had just been discharged from service and was waiting for a residency. The veteran appeared to have the same attributes as my associate. We needed additional help, particularly with outside work, so we invited him to join us.

As a result, we now have a well-knit unit with prospects for steady growth. We have remodeled our office so that two men can work at the same time and a third can come in to help. Each has a special

[PLEASE TURN TO PAGE 158]

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Phenylephrine Hydrochloride-Breon, by clearing the nasal airways, aids sinus drainage in head colds, vasomotor rhinitis, and sinusitis. It eases the harassed patient —one of those trifles that—done or neglected—make a physician liked or—the reverse.

Report Suggests Ways to Reduce The Cost of Medical Care

A formula is recommended for stretching medical funds

With the cost of living high enough to leave vapor trails, investigations into the cause have become a national pastime. If medical men find something vaguely reminiscent in this belated flurry, it's scarcely surprising. A probe target of long standing is "the high cost of medical care."

The nation's $5-billion-a-year sickness bill has been used repeatedly as an argument for tax-financed medical care for all. But thoughtful physicians are well aware that insurance, whether voluntary or compulsory, only *spreads* costs; it does not *lower* them. The sick person's savings are matched by the well person's losses.

THREE-WAY STRETCH

But what program could actually reduce the amount spent on medical bills without cutting necessary services? The problem has been studied by the Committee on Medicine and the Changing Order*. Its findings emphasize these practical methods:

¶ Get more use out of existing, high-cost medical facilities.

¶ Stop wasting money on quackery.

¶ Invest more in public health.

A three-pronged campaign of this sort, the committee believes, would reduce the total expenditure on medical care yet increase the amount of medical care available.

COSTLY RIDDLE

Its analysis shows that specialist services and diagnostic work account for the bulk of the doctor's bill. What's more, the committee points out, "these services are expensive because they are not fully utilized and they are not fully utilized partly because they are expensive."

Diagnostic centers are the committee's solution to this problem: "They increase the utilization of necessary equipment and decrease the waste of personnel time involved in waiting for patients. These centers may limit their services to X-ray and laboratory tests or they may also include consultation in various specialties."

Mount Sinai Hospital in New

*Formed by the New York Academy of Medicine to study the impact of social and economic changes on medical service. See June 1947 MEDICAL ECONOMICS for highlights of its final report.

York is cited as one center where this plan has helped whittle medical expenses. Patients within specified income brackets may, upon referral by a private physician, undergo a complete examination there for $40. The fee covers all the tests and consultations found necessary. A similar plan has met with success at Johns Hopkins.

Others view cooperative schemes like that of the Rhode Island Pathological Institute as a means of cutting costs. In that set-up five hospitals share the services of top-notch pathologists, bacteriologists, and biochemists. In the words of its founder: "We plan to provide a comprehensive pathological service for all local physicians. The low fees charged will be within the means of nearly all patients."

DOWN THE DRAIN

Money spent on incompetent therapy and diagnosis is money wasted, the analysts warn. Only by discouraging patronage of irregular practitioners and of regular practitioners who give slipshod service can this drain be checked, they say, adding that "State enforcement of licensing restrictions is one remedy, public enlightenment the other."

Another expense the committee would cut is that of unnecessary services: "Various technical procedures are employed when they are not needed. Unnecessary laboratory tests, for example, not only add to the costs directly, but may increase them indirectly by prolonging the patient's stay in the hospital. The same is true of unnecessary consultations."

Possible solution? "Physicians, particularly the younger ones, should be indoctrinated in the need for careful histories and physical examinations. Critical judgment in ordering tests or seeking consultation should be emphasized in medical schools. The same need for economy should be impressed by the heads of services on all physicians using hospital facilities."

Will public health campaigns lower the national health bill? One observer, Dr. Duncan W. Clark of the Long Island College of Medicine, says that a broad program of preventive service will jack up expenditures that are already high. But, he counters, "Over a period of years this larger investment will reap the dividends of better health and in the long run may prove less expensive."

To which the committee adds its amen, pointing to "enormous expenditures for the medical care of people whose illness arises principally because of inadequate housing, food, and sanitation." Many illnesses, it concludes, reach serious proportions "because of ignorance or because of reluctance to use available medical facilities. Higher living standards and health education would substantially reduce the over-all costs of medical care."

—ALLEN ELY

Working With the Health Agency

Lay organizations show willingness to accept leadership from medicine

Hard feelings between lay health agencies and physicians show signs of softening. Medicine has had three choices: to ignore the agencies, to abandon the field to them, to lead them. Now, a few societies have chosen to lead. And they are demonstrating that both agency bitterness at medicine's "noncooperation" and physicians' fears of patient-pirating can be minimized.

Over the years, many lay organizations have prospered in public repute and in financial support. Their boards of directors are studded with prominent people. Newspapers fall over one another to give them free promotional publicity and favorable editorial comment. Now, as a result, a county medical society can hardly embark on a community cancer control program without the support of the local chapter of the American Cancer Society. The same holds for drives on other diseases.

For medical societies to meet this problem by working with lay agencies and by contributing technical and civic leadership is consistent with item nine of the ten-point National Health Program of the American Medical Association: "Services rendered by philanthropic, volunteer health agencies should be encouraged." Of course, some societies have not found the job of cooperating easy. Unless they are content to string along uncritically, they soon encounter stumbling blocks to smooth relations. Here are seven points likely to cause disagreement:

¶ The agency may exploit the labors of physicians but so arrange its publicity that the public applause for health work will accrue entirely to the lay group rather than to the doctors. (One example is the famous National Foundation poster, "March of Dimes did this for me!")

¶ Some agencies profit financially from the work of the doctors. There is a growing tendency among such units to accept fees (or "special contributions") from patients able to pay them.

¶ Grievances about the work of M.D.'s are often channeled through lay officials who thus are in the position of passing judgment on doctors.

¶ The lay agency may select its physicians on a basis that does not

conform to the technical and ethical qualifications usually set up by medical officials.

¶ Diagnostic and prevention clinics may imperceptibly become treatment units. Their doctors thus compete unfairly with private practitioners.

¶ Agency workers almost automatically think of other *public* facilities when it is necessary to refer a patient. They are accustomed to thinking of medical resources in terms of clinics, hospitals, dispensaries, and welfare agencies rather than in terms of private doctors.

¶ Lay agencies use publicity methods that seem shocking to many doctors. Posters in store windows, copiously illustrated newspaper releases, slick brochures, and banners hung in public streets are standard money-raising tools. The practitioner is normally disturbed by a news photo showing a doctor at the controls of a new X-ray unit or by a poster displaying the picture of a colleague soulfully listening to the chest of an underprivileged child. Yet the agencies have a passion for this kind of publicity.

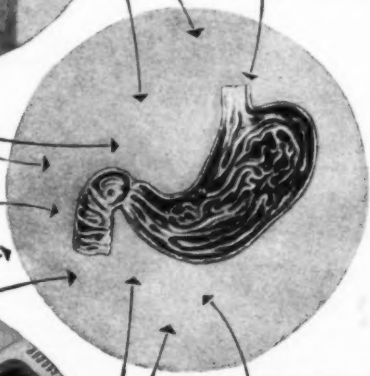
What can be done?

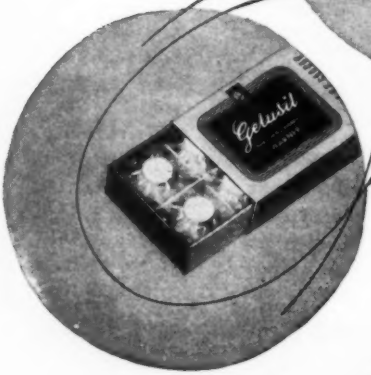
One approach is to prepare a set of *workable* principles to which both medical society and lay unit can adhere. In New Jersey, for instance, the state medical society adopted a set that was sweated out from actual experience in Monmouth County. There the local medical society and the health and welfare organizations had for twenty years teamed together to provide and staff a battery of prenatal, mental hygiene, venereal disease, and tuberculosis clinics. They had given high caliber service without invading private practice.

Analysis of the New Jersey principles, later adopted with modifications by the AMA, shows that the medical society promises to do these things: (1) pass on the qualifications of clinic physicians, (2) provide technical leadership, (3) appoint the necessary supervisory personnel, and (4) insure maintenance of high professional standards.

The social agency, in turn, pledges that it will: (1) gracefully accept the medical society's leadership, (2) appoint only such medical personnel as are approved by the society, (3) clear through the society all grievances concerning physicians, (4) shun financial profit from the labors of the doctors, (5) avoid treatment procedures in diagnostic or preventive clinics, and (6) return to the private practitioner any patient not entitled to clinic service.

These promises are refreshingly





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different from the usual noble generalizations developed at conferences between medical society leaders and social agency executives. They are specific, not general; workable, not theoretical.

Take a case in which a nonindigent patient is sent from the agency to a public clinic. This can be referred swiftly to the liaison committee. There is no room for argument since the agreement is specific.

Or suppose that an agency supervisor feels a doctor is neglecting his duties or exploiting his clinic contacts. This is handled, as it should be, through the medical society and not through the executive of the welfare agency.

Each lay agency binds itself to employ only those physicians who are acceptable to the medical society. Thus, organized medicine shields itself and protects the community against infiltration into the agency of any ill-qualified or incompletely indoctrinated physician.

Lay health agencies, if properly guided, can use their enormous good will and financial resources to complement the work of organized medicine rather than to compete with it. The principles cited show how medical leadership can be applied.—WILLIAM MACDONALD, M.D.

Catalyst

My friend had persuaded the airline to let him take his pedigreed Persian cat with him on a short flight. Knowing the beast was a hyperactive traveler, he appealed to me for help. Like any other cocksure interne, I told him to bring the cat around just before flight time and I'd fix everything. Accordingly, half an hour before their departure, I injected the animal with almost a grain of morphine.

Later my friend wrote: "I don't know how to thank you for your help with Lord Rutherford. Even as it was I could scarcely manage him. He was all over the walls and ceiling of the plane, scratched a young lady's face, and knocked the hat off an indignant old gentleman. I shudder to think what he would have been like if you *hadn't* given him the sedative."

That's when I recalled something about cats and morphine being an explosive mixture. I went straight to the books—and have never since forgotten that "opiates act as violent central nervous system stimulators on cats." —M.D., KANSAS

Serving medical progress through Phot

Writing for Medical Journals

Where to find provocative material for your medical articles

Many a doctor reads a spectacular case report in a professional journal and sighs, "Why don't I get cases like that?"

Chances are, he does. But if he fails to keep a weather eye cocked for them, good article leads may pass right under his nose. Few tips to the budding medical writer pay off as well as this one: *Look first for the interesting features of your own practice.*

Suppose you administer viburnum to a patient. The next day he phones to say: "I've been seeing double since I woke up this morning. The only thing I drank last night was the medicine you gave me. Do you think it could have been that?"

You don't really know. A hurried search of the literature fails to turn up any reports of diplopia as a side-effect of viburnum medication. A few days later the patient's diplopia disappears. He feels better and so do you.

But don't let it go at that. The alert fact-chaser makes a note of such a case. When time permits, he delves into a medical index. He confirms the fact that the disorder has never been reported before. Thereafter he keeps a close check on all patients to whom he administers viburnum. When he gets a second such complication, he puts together a concise report and sends it to his state medical journal for publication.

He has thus made a permanent, if modest, contribution to medical knowledge. A decade hence, someone else may make the same observation, scan the literature, and find the report. His paper may then begin: "Since 1947, when Smith first described diplopia as a concomitant of viburnum therapy . . ."

STALKING THE IDEA

Probably the best means of tracking down interesting cases is a diagnostic file. You can, for example, slip numbered metal signals onto certain of your case record cards,

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► This article is the seventh and last of a series prepared by Dr. Henry A. Davidson, editor of the Journal of the Medical Society of New Jersey. His first installment appeared in January.

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letting each number represent a major diagnostic classification. Cards of patients with like disorders can then be spotted quickly. As you add notes on results of treatment and on complications, you're likely in time to build up a file of material that's well worth reviewing for publication.

Physicians often put a new twist in some technical procedure without realizing its novelty. You may have found, for instance, that a lumbar puncture is done better in an unusual position. Or you may have modified the apparatus used in standard procedures (such as blood counts, injections, clyses) to meet some special need. Either type of innovation may contain the germ of a journal report.

Not all papers read at medical meetings can be converted into journal articles. To break into print, your paper must not only review the literature on one topic; it must add your own experiences as well. If you find that certain signs not stressed in past articles are especially valuable, report that fact. If you find that certain diagnostic clues emphasized in the literature are clinically unimportant, report that too. New slants like these are what medical editors want.

PROBING THE PAST

Before preparing a scientific paper, be sure to scan carefully all background literature. You cannot, of course, report an "unusual" case unless a search of past material clinches the fact that it is rare.

Suppose one of your patients

shows a peculiar skin reaction to penicillin. You feel that many of your colleagues have not paid enough attention to penicillin's dermatologic side-effects. You decide to report your case, attaching a general discussion of how to manage such complications.

As a starter, you leaf through the standard texts, abstracting what they have to say on the subject. But since books become obsolete quickly, they can rarely be cited in medical papers. So you turn next to the periodical literature.

The *Index Medicus* is likely to be your most useful research tool.* This AMA publication lists all medical articles published during a given half-year period; it classifies and cross-indexes them in great detail. Start with the latest volume under the key words "penicillin" and "dermatitis." Look for pertinent subheadings such as "Penicillin, untoward effects of" and "Dermatitis—caused by penicillin."

After you've culled all promising references from the latest *Index Medicus*, go back one volume at a time until your patience or your supply of indices gives out. In most cases a ten-volume search will do the trick, since some writer is likely to have summarized the earlier literature during that five-year period.

There's one hitch to using the *Index Medicus:* Unless you can get to the library of a large medical society, an academy of medicine, or a large hospital, you may not be able to lay hands on a copy. In that case, your best move is to examine the indices appearing twice a year in the index numbers of the Journal AMA. Abstracts of nearly all important articles in other journals are listed there.

Still another guide to periodical literature is the year book of the appropriate specialty. In the example given, you'd consult the Year Book of Dermatology and the Year Book of Internal Medicine. A friend in the specialty should be able to give you access to the volumes you want.

ASSEMBLY LINE

By this time you have a long list of titles, authors, periodicals, and dates. Next step is to get the articles themselves. If you are near a good medical library, this is no problem. The more familiar periodicals will be found on its shelves. The others can be borrowed through loan collections.

You can tap the facilities of the Army Medical Library through any public, hospital, or university li-

*Theoretically, the most complete medical index is the Index Catalogue of the Library of the Surgeon General's Office. But this monumental work is less accessible than the Index Medicus and is several years behind schedule.

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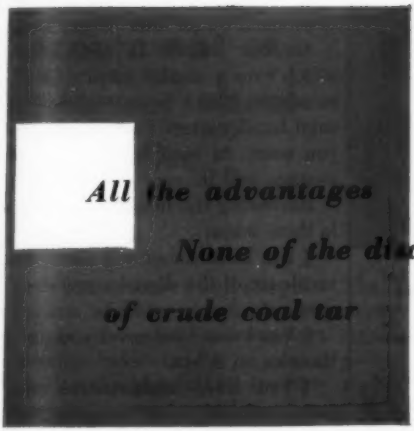

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brary. For the price of the postage, nearly anything that's in this storehouse of learning is yours for two weeks. Tell your local librarian what articles you want. He'll forward your request to Washington, from which the material will be dispatched on an inter-library loan.

Another source is the AMA, which runs a similar service for its members. Write direct to the Chicago headquarters for the material you want. In most cases, two-way postage will be your only expense.

Reviewing the literature pays off in three ways:

¶ You learn something about the incidence of the disorder you're reporting.

¶ You know how novel your own theories on it are.

¶ You have authoritative material on hand to back up your own statements of fact.

There's just one thing left to do: Sit down and write your article.

Don't overlook the value of brief

*P*atients

¶ Who was your most unusual patient? What made him unforgettable? MEDICAL ECONOMICS will pay you four cents per published word (a minimum of $5) for an acceptable answer. Requests for anonymity respected.

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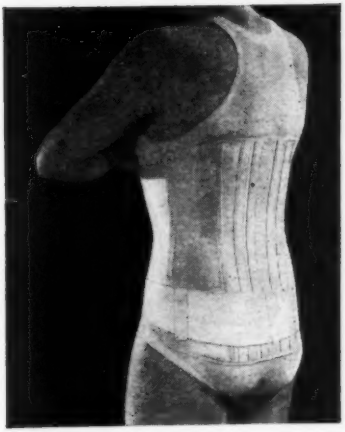
A Spencer as adjunct to treatment of intervertebral disc



In both conservative and surgical treatment of intervertebral disc, the application of a back support is usually indicated.*

We invite the physician's investigation of Spencer as adjunct to treatment. Each Spencer is individually designed, cut, and made for each patient—after a description of the patient's body and posture has been recorded and detailed measurements taken. Thus, individual support requirements are accurately met.

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For information about Spencer Supports, telephone your local "Spencer corsetiere" or "Spencer Support Shop", or send coupon at right.

*Barr, Joseph S., *Ruptured Intervertebral Disc and Sciatic Pain*, Jr. Bone and Joint Surg., 29: 429-437 (April) 1947.

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letters-to-the-editor to fill in the gaps of previously published, full-length reports. One general practitioner, for example, discovered that a boy had accidentally vaccinated himself by wrestling with a youngster who had just been vaccinated in the conventional manner. The doctor was alert enough to sense that this was worth reporting. He was also sensible enough not to write a complete treatise on vaccination from the days of Jenner to the atomic bomb. He simply mailed in a one-page report on the facts of the case.

Medical editors are hungry for such material. Pithiness and oddity assure prompt publication, wide readership.

—HENRY A. DAVIDSON, M.D.

Just Published

ARTICLES

THE BATTLE IS JOINED. By Robert H. Felix, M.D. A report of the first year and future plans of the National Mental Health Program. Survey Midmonthly, September.

VETERANS' MEDICINE: SECOND TO NONE! By Lois M. Miller and James Monahan. A resume of the accomplishments of the V.A. hospital and medical care program in the two years of General Bradley's administration. Reader's Digest, September.

[PLEASE TURN TO PAGE 124]

DOCTOR ALONG THE BOARDWALK. By Bernard DeVoto. A veteran editor and writer visits the AMA centennial meeting and records his impressions – complimentary and otherwise. Harper's, September.

BOOKLETS

COMPULSORY HEALTH INSURANCE. By Elizabeth W. Wilson. A review of the demand for Federal health legislation in the United States, with an analysis of the economic, administrative, and medical problems raised by the proposed plans. 138 pp. National Industrial Conference Board. New York. $1.

THE HOSPITAL SURVEY AND CONSTRUCTION ACT. WHY WE NEED MORE HOSPITALS. THE HOSPITAL ACT AND YOUR COMMUNITY. HOSPITAL QUIZ. WHAT IS A HOSPITAL SYSTEM? A series of pamphlets designed to explain the essential features of the Hill-Burton Hospital Construction Act and its application to local communities. U.S. Public Health Service, Washington, D. C. No charge.

BOOKS

MEDICAL CARE AND COST IN RELATION TO FAMILY INCOME. Selected and compiled by Helen Hollingsworth, Margaret C. Klem, and Anne Mae Baney. Bureau of Research and Statistics, Social Security Administra-

[PLEASE TURN TO PAGE 126]

tion, Federal Security Agency, Second edition of a statistical report that contains 317 tables on medical care needs and expenditures, health personnel and facilities, and health insurance plans in the U.S. 352 pp. U.S. Government Printing Office, Washington, D.C. $1.25.

THE SECOND FORTY YEARS. By Edward J. Stieglitz, M.D. For the layman over 40 Doctor Stieglitz offers a guide for a sensible and longer life. 318 pp. J. B. Lippincott, Philadelphia. $2.95.

THE DEVELOPMENT OF MODERN MEDICINE. By Richard H. Shryock. Revised and enlarged edition of a book first published in 1936. Studies the development of medical science and practice in relation to social and economic conditions. 458 pp. Alfred A. Knopf, New York.

DOCTORS OF TODAY AND TOMORROW. By Michael A. Shadid, M.D. The founder of a cooperative hospital in Oklahoma discusses the inadequacies of present-day medical service and describes the organization and administration of cooperative medicine. 292 pp. Cooperative League, New York. $2.25.

TAKE THREE DOCTORS. By Elizabeth Seifert. A fictional story of the conflict between three doctors in a small town. 218 pp. Dodd, Mead, New York. $2.50.

Medicine Looks at the Co-ops

Study is aimed at finding out how much control consumers exert

"No one type of voluntary health insurance plan can reach all the people. It takes all kinds: Blue Cross, medical society plans, commercial plans, and cooperatives." A month ago the AMA, having drawn up that recipe, was busy weighing its least understood ingredient: the health cooperative.

Few things have made medicine's pot boil the way the co-ops have. Still fresh in AMA memories is the anti-trust action stirred up by Washington's Group Health Association.

Last year the co-ops achieved national stature by banding together as the Cooperative Health Federation of America. Soon afterward, AMA delegates resolved that it was time to find out what was cooking. They gave their nod to a survey that so far has turned up ninety-two health co-ops in thirty-one states.

More than 750,000 persons* belong to health cooperatives. Three-quarters of them live in farm areas. Because co-ops have in some cases brought the advantages of group practice, assured income, and modern facilities to the country, they are popular with a number of rural physicians.

How co-ops affect the M.D. is shown by a quick glance at The Community Health Association of Elk City, Okla. It gives general medical care to 10,000 low-income farm people for $9 to $16 a year per individual. To provide co-op doctors with their initial facilities, members paid $50 apiece. Today the group owns a 100-bed hospital.

SALARIED PHYSICIANS

Elk City's co-op physicians receive salaries of $600 a month plus 50 per cent of their fees for treating non-members. A medical director, who gets $700 a month, controls the professional aspects of the plan. Subscribers meet once a year to transact co-op business. The rest of the year a board of trustees carries out their policies.

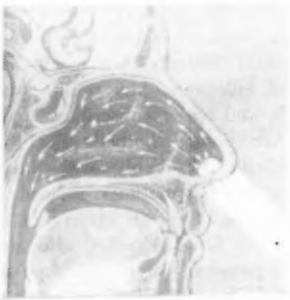
Another co-op, New York's Group Health Cooperative, was set up with a family income limit of $3,600. Its pattern is like that of Elk City. Annual dues are $17 to $23 an individual. Any licensed

*The AMA's enrollment figures (some of them several years old) for seventy-two of the ninety-two medical cooperatives total 504,000.

Unlike some fluids, volatile vasoconstrictors "do not spread the infection and may be used in the acute stages of the attack."

Proetz, A. W.: Ann. Otol., Rhin. & Laryng. 54:91.

Benzedrine Inhaler therapy does not spread infection



Liquid medication, applied to the rhinological tract, may carry pathogenic organisms from affected to uninvolved tissues. But because its active ingredient is a vapor, Benzedrine Inhaler, N.N.R., does not thus transmit infection.

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Benzedrine Inhaler

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physician in the area is eligible for a staff contract. He is paid according to a schedule based on capitation and unit fees. Members get general medical care, pay extra for maternity services and house calls. This co-op has 22,000 subscribers.

With many co-op ingredients, physicians find no fault.. Group practice, preventive medicine, and prepayment are certainly palatable to the profession at large. Free choice is limited, but no more than in most groups, and joining is voluntary for both physicians and patients.

• LAY CONTROL

But what about consumer control? More than any other, that question has split medicine and the the co-ops. Medicine has never relaxed its insistence that doctors control everything touching the professional side of practice. To many physicians, co-ops appear to have given their members the whip hand.

But some AMA officers think their survey will show less of a gap between co-ops and medical society plans than has often been thought to exist. Says one: "Physicians don't want to control business matters that have nothing to do with their practice. And consumers certainly don't want to tell doctors what to prescribe. I think our study will show there's not much difference between 'consumer control' of co-ops and 'physician control' of other voluntary plans."

Whatever the survey may reveal, it is plain that the AMA still remembers a warning sounded by Raymond Rich: "Current medical policy," the public relations counsel said, "makes too much of complete medical control. That means lowered efficiency, less public goodwill, and fewer subscribers."

Are co-ops hotbeds for state medicine? Probably not, though they have sometimes seemed so. Even as bitter an enemy of the AMA as Dr. Michael Shadid, a co-op pioneer, says: "Compulsory health insurance would serve no useful purpose as far as we're concerned. It could more easily prove disastrous by breaking up bene-

ficial co-ops now existing." He agrees that co-ops cannot carry the whole load. But "if bolstered by Government aid for the indigent and by Government research in 'incurable' diseases, they may go a long way toward solving the rural health problem."

EARLY ERRORS

Doctor Shadid admits that early co-ops made some bad mistakes. They failed to cooperate with local physicians; as a result, they were often professionally inferior. They laid themselves open to "price-slicing" charges by giving discounts instead of by establishing dues. And some of their agents, Doctor Shadid recalls, used unethical solicitation methods.

Today many of those sore spots have been remedied. Co-op leaders now insist that their plans work in harmony with M.D.'s. The AMA reports a number of consumer-sponsored plans seeking the advice of local physicians. It concludes: "This may give us a chance to fit these plans into community medical care activities compatible with medicine's principles."

Peculiarly adapted to rural regions, co-ops cannot be expected to burgeon like other voluntary health insurance plans. None so far has had remarkable acceptance. The two largest, according to a recent report, are the Ohio Farm Bureau (enrollment 60,000) and Group Health, St. Paul, Minn. (enrollment 50,000). Because the average consumer-controlled plan has perhaps 7,500 subscribers, many have experienced tough sledding financially.

Despite their limitations, co-ops are serving a number of areas that other voluntary health insurance plans have not reached. For that reason alone, medicine's current survey of these agencies is well worth while. —EDWARD E. RYAN

Prepay Plans

[*Continued from page* 40]

membership and organization. He was recently rewarded with a promise of a larger staff and a three-year contract.

Before that contract runs out, Smith may find the time ripe for things some men would like to see now but feel are still a long way off. They include:

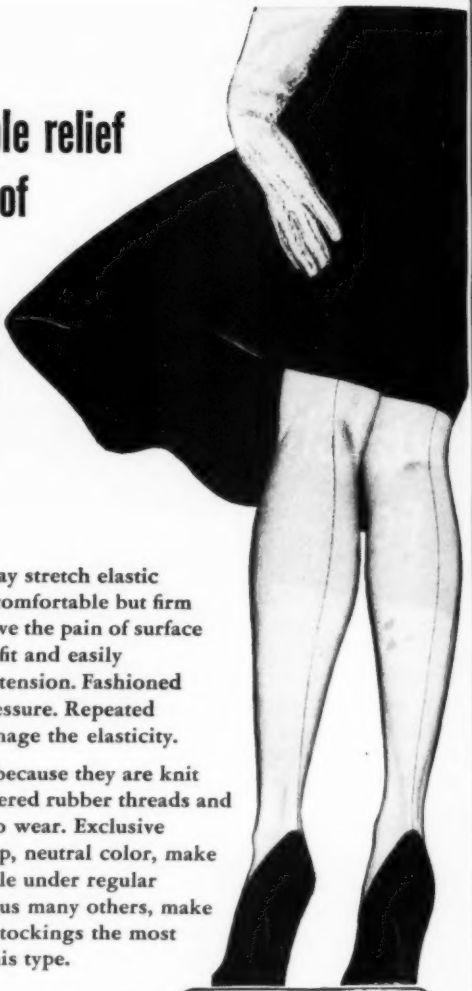
¶ Unification of Blue Cross and AMCP.

¶ Amalgamation of hospital and medical plans.

¶ Participation by more business men in the policy-making and control of prepayment plans.

—EDMUND R. BECKWITH, JR.

For comfortable relief from pain of surface VARICOSE VEINS



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'Cheap Medicine' Sends Municipal Prepay Plan Into Nosedive

Physicians resign en masse when told to cut patient care

When the Health Service System of San Francisco blew apart a month ago, the explosion reddened many a face in California and Washington. Proponents of Warren- and Wagner-type sickness insurance had long regarded this early (1937) essay into government medicine as a shining example of what might be expected of a national system. It had proved to be exactly that.

Word had gone out that the insurance fund was in parlous shape and that doctors would have to cut down on the service they were giving subscribers. The reply from San Francisco's doctors (most of whom participated in the plan) was emphatic: "We have taken a cut in our fees without balking. But when it comes to cutting the quality of medical care, count us out."

Those who were members of the San Francisco Medical Society sent in prompt HSS resignations. Most non-members indicated they would follow suit.

The plan around which this controversy boiled was a municipal enterprise that San Francisco voters had sanctioned in a 1937 referendum. Enrollment was compulsory for San Francisco's 12,000 employes, optional for their dependents (of whom 6,000 had subscribed). Premiums were paid through payroll deductions. For $3.40 a month, the average employe got surgical, medical, and maternity benefits, and twenty-one days' hospitalization.

The San Francisco County Medical Society had voiced repeated objections to the plan's shaky financial structure. Last year for example, with an income of $529,330, HSS had shown an operating loss of $37,578. To climb out of this hole, HSS had increased its premium rate 25 per cent. Despite this rate rise, physicians were being paid only 85 cents on the dollar.

Finally, Dr. Alexander S. Keenan, medical director, sent out an appeal to participating doctors to reduce their services. Said he: "It would seem that any physician can make a diagnosis without leaning so much upon the laboratories and the X-ray departments. In making a survey of the results of several

hundred examinations, particularly reports from the X-ray laboratories, I feel safe in saying that between 50 and 60 per cent of them were unnecessary."

San Francisco's medical society countered with a devastating analysis of the HSS set-up and administration. To Doctor Keenan's plea for reduced service, it said: "What type of medical practice do you think we would have if we failed, through false economy, to make proper diagnoses?"

The society also pointed out that X-ray and clinical tests accounted for only $33,044 in 1946, so that even if such tests had been eliminated, HSS would still have operated at a deficit.

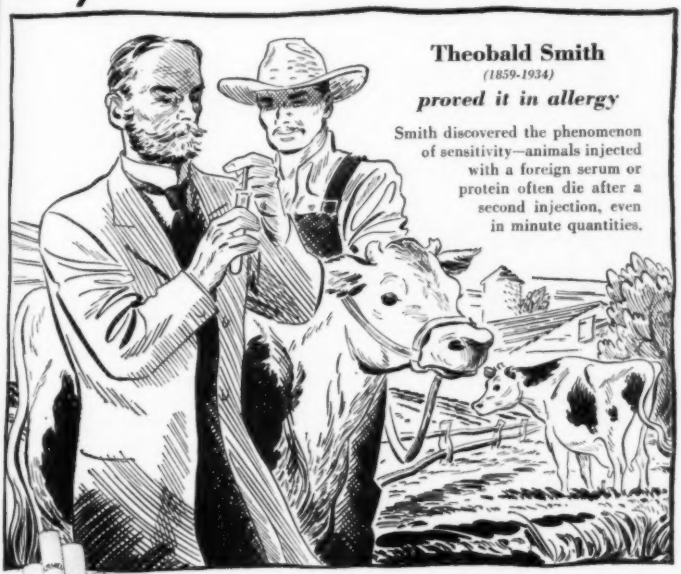
Doctor Keenan's appeal charged that the public had gained "a mass of false information" about medicine from magazines, newspapers, and the radio. This had caused many "unnecessary" visits to doctors for "trivial" illnesses which patients could have cleared up with "home remedies."

Local physicians attacked this statement with gusto. The press chimed in. Commented one of the area's leading newspapers: "The medical director appealed to doctors to reduce the amount and quality of service rendered — a preposterous suggestion . . ."

At month's end, HSS was in a state of suspended animation. Its board of directors had tabled medical society protests and voted confidence in Doctor Keenan.

—RONALD C. LAIN

Experience is the Best Teacher



Theobald Smith
(1859-1934)
proved it in allergy

Smith discovered the phenomenon of sensitivity—animals injected with a foreign serum or protein often die after a second injection, even in minute quantities.

Yes, and experience is the best teacher in smoking too!

EXPERIENCE during the wartime cigarette shortage taught smokers the differences in cigarette quality. In those days, people smoked—and compared—many different brands. Many smokers learned that Camels suit them best. **As a result, more people are smoking Camels than ever before.**

According to a Nationwide survey:

MORE DOCTORS SMOKE CAMELS

than any other cigarette

R. J. Reynolds Tobacco Co., Winston-Salem, N. C.

Meet Mary Fidget . . .

Now Mary had Pruritus
I'm sorry to relate
To grin and bear this awful itch
Was Mary's sorry fate
She simply couldn't scratch it,
While everyone was gazing
She was roiled, and squirmed,
and boiled and burned,
How she stood it was amazing.

MORAL: She should have gone to her doctor. He knows that the distressing itching, and the embarrassment associated with pruritus vulvae, and also with pruritus ani and intertrigo, is promptly relieved with ENZO-CAL the soft, pleasing greaseless cream, with the rose odor, containing semi-colloidal calamine and zinc oxide, with benzocaine.

Beat the Quack at His Own Game!

The medical charlatan is a past-master at making patients feel important

Some people are intimidated by the austerity of the medical profession and by its complicated terminology. That's why they consult quacks and cultists. The latter have a knack of making themselves understood and getting next to the patient.

When physicians meet patients on their own ground, they help scuttle the quack quick. Physicians who do that have learned why the quack functions so successfully and why he attracts the many patients he does.

The charlatan's aims are indisputably fraudulent. But he frequently employs sound, fundamental psychological principles that may be used also by the average physician—with discretion.

The successful quack attempts to explain the patient's condition to him as brother to brother, in simple language. And, after all, who won't listen when *his* dyspepsia or backache is the topic of conversation? It is comforting to the patient to know that someone has the ability to understand why he sees spots in front of his eyes or why he feels down at the mouth.

The quack pats the patient's intelligence on the back. He speaks his language. He is his confidant. A stock assurance of the quack is that he will not get impatient, nor smile at the individual's worries, nor put him off with vague replies.

Medical knowledge is admittedly complicated and abstruse. But if it is to percolate down to the masses through legitimate pipelines, it must be simplified and made easy to digest. Technical language is to be avoided above all. The layman understands immediately when you refer to his cold. Coryza, on the other hand, may mean anything to him from the name of a Spanish general to a species of tropical fish. Hardening of the arteries likewise elicits his understanding. Whereas he probably can't even pronounce arteriosclerosis, much less define it.

The mere fact that he is ill or that he is likely to become ill is not always enough to convince a man that he needs medical service. He must be sold the idea. If he won't listen to nature's signals or to the dictates of common sense, he must be persuaded and convinced. No hocus-pocus is necessary to achieve

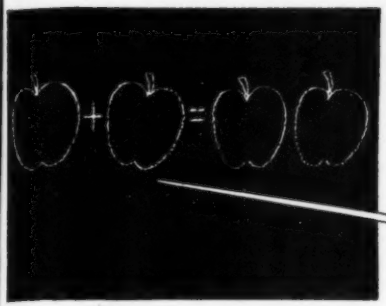
this. It requires merely an application of the principles of human psychology and a knowledge of what makes people want to be healthy.

The quack has learned that men and women buy spurious medical advice for the same reason that they buy reliable medical advice: because of an unconscious desire to be more adequate and more masculine (or feminine, as the case may be), and because of an equally unconscious desire for romance and for life. The principles that psychoanalysis has shown to underlie human motives and actions are put to use regularly by charlatans in attracting patients.

SEX APPEAL COUNTS

Not only do men and women want to be free from sickness and pain, but they also want to be attractive. The mental torture that may come from an unattractive and unappealing figure or face may be every bit as real and as deserving of attention as the anguish of a broken limb. These problems are of vital concern to the physician who realizes that he is treating people, not cases.

Lotions and salves to build muscles or "charm" and secret formulae drugs to enhance vital powers or the size of the bust will always be attractive to certain types of patients as long as their physicians ignore the motives that drive these poor unfortunates into the arms of the quack. The physician must realize that "manhood" may be more important to a man than his appendix, and that a woman's



SIMPLE, isn't it?

And it's just as simple to maintain complete, accurate records of your calls, receipts and expenses with the "Histacount" system. A few minutes a day is all it takes . . . bookkeeping drudgery is eliminated, doubts and guesses removed, tax overpayments avoided. For $6.75 you receive a loose-leaf or plastic-bound book of 365 daily record pages, 12 monthly and one annual summary sheets, social security and other tax forms, and complete instructions . . . refills for the loose-leaf system cost only $3.35 a year. So simple, so easy and dependable, once you use the "Histacount" record system you'll consider no other.

Let us send "Histacount" for your inspection . . . if you return it within 20 days in good condition the purchase price will be refunded immediately.

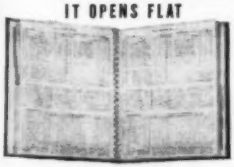
MORE THAN 50,000 DOCTORS USE

HISTACOUNT

DOCTORS' OFFICE RECORDS

MAIL COUPON FOR 20 DAY FREE TRIAL OR FULL DETAILS

IT OPENS FLAT



IT LIES FLAT

PROFESSIONAL PRINTING CO., INC.
15 East 22nd St., New York 10, N. Y.

Send me, on 20 day approval, your simplified "Histacount" record system in ☐ Loose-leaf form ☐ Plastic-bound form.

Enclosed is my ☐ check, ☐ money order for $6.75, or ☐ send C.O.D. It is understood that if I return the "Histacount" within 20 days you will refund the $6.75 at once.

☐ Send full details on "Histacount". MH

Dr. .....

Street .....

City..... State.....

"Histacount" IS ALSO AVAILABLE AT YOUR SURGICAL SUPPLY HOUSE.

sex appeal may mean more to her than her asthma or varicose veins.

The quack treats his patient as a whole—not in separate segments as is often the custom in specialized medicine. He has stumbled on the great but simple truth that the human organism is not a series of compartments but a well-integrated totality. He realizes that not only do his patients have eyes and arms and hearts, but that they also have minds and feelings, and that you cannot ignore the one for the other.

The medical faker doesn't treat a prostate gland. He treats a patient who has fears and hopes, domestic troubles and financial worries.

The physician must remember that although he has earned his medical degree and the right to practice, he has not relinquished the need of applying his knowledge of human nature and of using common-sense psychotherapeutics. These are as essential in medicine as they are in all other professions, trades, and businesses.

NO TWO OF A KIND

The quack knows his public. He envisions it for what it is: a heterogeny of doormen and ditch-diggers, scenario writers and second-hand furniture dealers. He sees it also as a broad mixture of all races, nationalities, levels of intelligence, temperaments, and degrees of sophistication. His patients are not particularly different from those of reputable physicians. But because the quack appreciates the limitless differences in the mental and physical makeup of people, each one who comes to his office is assured a unique, individualized approach.

A quack dictum that might appropriately be observed by physicians everywhere is this: *meet the patient on his own level.*

The role of the physician is not a passive, objective one. The notion of a doctor looking at a patient through a microscope as though he were a germ waiting to be classified and pigeon-holed deserves no place in medicine today.

Faith-healing has for its basis the rather intangible but real relationship between body and mind. It is a known fact that emotional exhilaration will decrease the duration of certain illnesses whereas emotional depression will produce just the opposite effect. A little smile, a little hope, a little faith in one's ability to cure are trifles that cost nothing but go a long way in giving the patient the *will* to get well.

The quack knows these things. He has found that the surest cure is the *belief* in cure. It is a mental shot in the arm that he injects con-

the NEW spasmolytic in liquid

• Robins' "Donnatal Elixir"* marks an important step forward in spasmolytic therapy. Developed for adults and children alike, this outstanding spasmolytic and sedative now greatly widens the range of its therapeutic usefulness.

• As an elixir, its exceptional palatability . . . its ease of administration and flexibility of dosage . . . together with its prompt, uniform action—all make it the spasmolytic of choice in such pediatric conditions as spastic pyloric stenosis, intestinal colic, diarrhea and enuresis.

• Donnatal's comprehensive spasmolytic effect—with an unusually wide margin of therapeutic safety—results from a synergistic combination of small, fixed amounts of the principal belladonna alkaloids, with phenobarbital. Each 5 cc. (1 teaspoonful) of Donnatal Elixir equals 1 Donnatal tablet in therapeutic effectiveness.

*"Donnatal" is the registered trade mark of A. H. Robins Co.

Ethical Pharmaceuticals of Merit since 1878

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DONNATAL

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rbital.
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AL

DOSAGE

Infants: ⅓ teaspoonful 2 or 3 times daily as necessary.

Children: 1 teaspoonful 2 or 3 times daily as necessary.

Adults: 1 or 2 teaspoonfuls, 3 or 4 times daily.

FORMULA

Each teaspoonful (5 cc.) contains:
Hyoscyamine Sulfate, 0.1037 mg.
Atropine Sulfate, 0.0194 mg.
Hyoscine Hydrobromide, 0.0065 mg.
Phenobarbital (¼ gr.), 16.2 mg.

AVAILABLE

In pints and gallons.

elixir another Robins' triumph

tinuously into his patients. He has learned that where his worthless nostrums fail, faith may succeed.

How can Mrs. Jones possibly feel confident in Doctor Smith's treatment if he himself appears to have one foot in the grave? The attempt of the bald barber to sell hair restorer to a skeptical customer is no less futile. The medical charlatan reinforces his selling points by the picture of his own good physical condition.

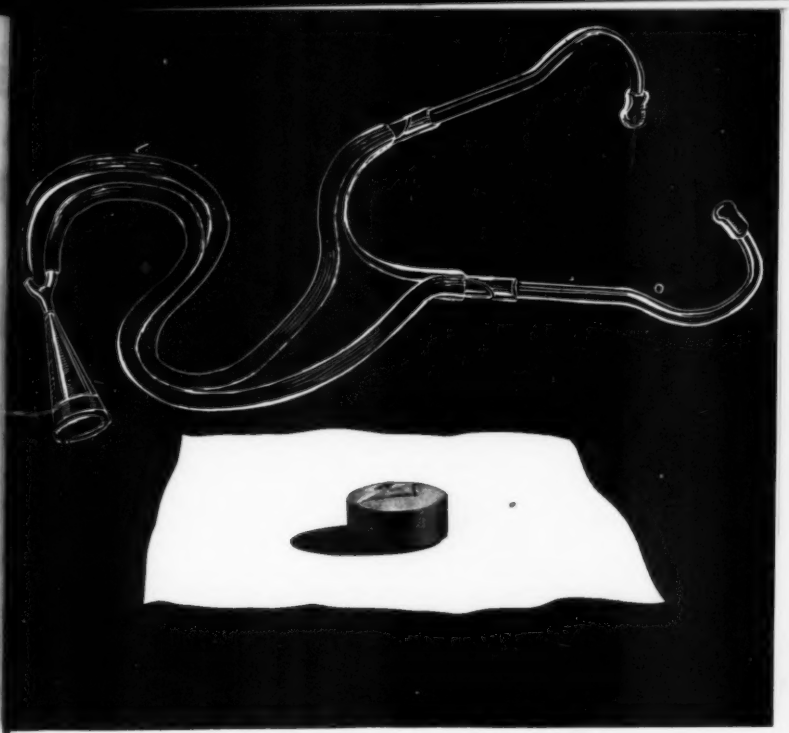
Conversation is another sometimes-neglected art in medicine. A good conversationalist is more than just an interesting talker. He is also a professional listener. The quack has noted that fully as many people suffer from lack of an audience as from lack of health. They are looking for any willing ear into which to pour their troubles.

This is a form of therapeusis that is fully as effective sometimes as drugs and operations. The need for it is more widespread than some physicians know or care to admit.

The ordinary patient wants his doctor to be not only a medical savior but also a father confessor and an inspirer of new hopes, new interests, and new purposes. If the patient is to be rescued from the ever-growing tentacles of charlatanry, it is imperative that every effort be made by physicians to come down to earth, to regain the human touch, and to share the common problems of mankind.

If the quack is to be beaten, it must be at his own game.

—HYMAN GOLDSTEIN, PH.D



Speaking of examinations!

You should see Whitehall's staff of graduate pharmaceutical chemists put Anacin through its paces! Qualitative analyses to determine purity and dependability; quantitative examinations to verify accurate composition; inspections to certify uniformity—this is the rigorous routine employed to assure the uncompromising quality and quick, effective results for which Anacin is known. Consider Anacin the next time you encounter simple headache, minor neuralgia or dysmenorrhea.

Fast-Acting . . . Long-Lasting

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Insuring Your Property Against Theft

An expert's tips for broadening your coverage at minimum cost

While insurance against household fire losses is fairly widespread, protection against the hazards of theft is often lacking. The prohibitive cost that such insurance seems to demand is one reason why householders put it off. Their decision is further strengthened by an improper understanding of the coverage it provides.

Perhaps you are under the impression that theft insurance is merely a burglary policy to cover losses when your premises are broken into. Actually, the theft policy covers not only burglary but also larceny, (any unlawful taking of property) and robbery (any loss where violence or threat of violence is used to induce you to part with your property).

The policy likewise covers "mysterious disappearance," which is presumed to be due to theft. Under this provision, almost any loss of insured property is included, even if you don't know when or how the loss took place.

TRAVEL LOSSES, TOO

Insured at the same time are losses caused by vandalism and malicious mischief. And in the event of burglary on your premises, the policy indemnifies you for damage inflicted by the burglars in their search for valuables. Still further protection can be had by adding a "theft-away-from-premises" clause. This covers loss of insured property anywhere in the Western Hemisphere.

It is thus obvious that a properly written theft policy is fairly comprehensive in its scope. The loss of your wife's luggage on a train, a hold-up of your son on his way home from the theatre, your daughter's handbag misplaced in a restaurant, your pocket picked, the laundry stolen from the basement —all are losses that can be cov-

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► This article (copyright 1947 by Philip Gordis) approximates a portion of Mr. Gordis' book, "How to Buy Insurance" (W. W. Norton & Co.). It offers pointers on how to adapt the theft policy to your individual needs, what type of company to purchase from, and how to save money in the process.

---

ered in one policy.

To set up a theft insurance program, first determine the amount of coverage you need. Use your fire insurance inventory as a guide, but in this case figure only the property likely to be stolen or damaged. You will get the best dollar values in theft insurance by dividing the property to be insured into three groups:

In Group 1 list the more valuable items that might be stolen. Describe each item in this group separately and state its value.

Group 2 embraces jewelry only. In this group, include all jewelry not listed in Group 1. Don't describe the items separately; simply set one figure in dollars to cover the aggregate value.

In Group 3 include all other property. Start by taking into account the portable items most likely to be stolen. List the family's clothing, linens, clocks, lamps, tableware, radios, typewriters, golf clubs, cameras, and fishing equipment. Then add cash on hand (up to $100) plus securities (up to $500).

When you have decided how much insurance will cover these items, add, say, 20 per cent to cover possible damage to doors, windows, and furniture caused by burglars plying their craft.

Formerly $1,000 of the valuable "theft - away - from - the - premises" coverage was granted free in most states. Now nearly all require the payment of an extra premium for this protection. But it's worth buying.

THREE-YEAR CONTRACT

A residence theft policy should be written for three years. The rate for three-year policies is two and a half times the annual rate, so you save a half year's premium. Even considering interest lost on the ad-

[PLEASE TURN TO PAGE 154]

A Great Antibiotic

TYROTHRICIN

More effective this new way

Dramatic, Rapid Response in Many Case

• Tyrothricin is a powerful antibacterial substance and an active healing agent.

Now you can employ all the benefits of tyrothricin therapy merely by applying Intraderm Skin Penetrant—Tyrothricin Solution to the affected site. You get quicker healing because:

1. **The skin penetrant liquid delivers the tyrothricin to the site of the infection.**
2. **The tyrothricin is *in true solution*, many times more effective than the suspensions.**
3. **Intraderm Tyrothricin is soothing and can be used in acute inflammatory stages.**

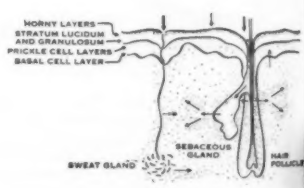
Intraderm Tyrothricin has been used with dramatic success in hundreds of cases of pyodermas and other conditions associated with gram-positive organisms.

Intraderm Tyrothricin is a clear, slightly amber solution with low surface tension. Hypoallergenic, mildly antiphlogistic. Each cc. contains 1,000 micrograms of tyrothricin.

Effective in treating

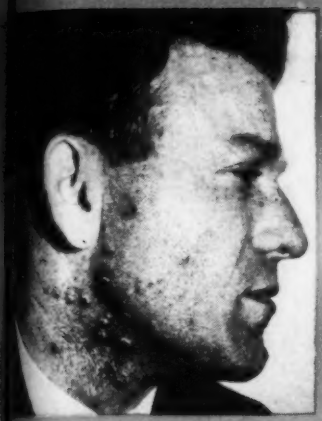
Folliculitis	**Carbuncles**
Sycosis Vulgaris	**Abscesses**
Furuncles	**Varicose Ulcers**
Impetigo	**Diabetic Ulcers**

— and other conditions associated with gram-positive organisms.

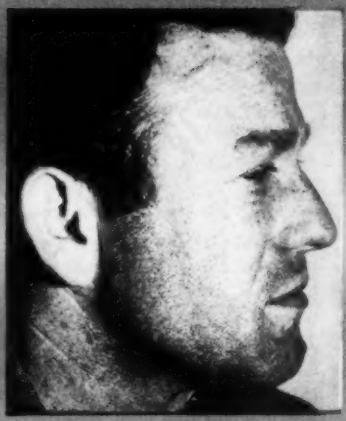


How Intraderm Principle Works

Intraderm Solutions penetrate the int human skin through the hair follicles a sebaceous glands and to a lesser deg through the sweat glands. The routes shown by the arrows in the diagr above.



Folliculitis barbae. Treated 2 months with penicillin, and with various lotions.



After 2 weeks' treatment nightly with wet compresses of equal parts Intraderm Tyrothricin and boiled water.

Case BACKED BY 5 YEARS OF CLINICAL RESEARCH

The Intraderm principle of skin penetration was developed over a 5-year period by a group of investigators seeking more effective methods of treatment.

Clinical results proved that Intraderm Tyrothricin's penetrant qualities and powerful bactericidal action on gram-positive organisms gave favorable response in 232 patients.[1]

[1] *MacKee, G. M., Sulzberger, M. B., Herrmann, F., and Karp, F. L., J. Invest Derm. 7:175 (1946).*

Free from Limitations of Penicillin and Sulfonamides

Unlike penicillin, Intraderm Tyrothricin is stable and needs no refrigeration. It kills most organisms faster than penicillin.

Unlike the sulfonamides, which often require hours to become effective, Intraderm Tyrothricin is bactericidal on contact. It is far more effective in tissue infections than sulfathiazole.

Unlike penicillin and the sulfonamides, tyrothricin has no record of causing sensitization.

INTRADERM
REG. U. S. PAT. OFF.
TYROTHRICIN
PRESCRIPTION AT DRUG STORES
WALLACE LABORATORIES, INC.
PRINCETON, N. J.

USE COUPON FOR SAMPLE

Wallace Laboratories, Inc. ME 11-47
Princeton, N. J.

Please send sample and literature on Intraderm Tyrothricin.

Doctor_____

Street_____

City_____ State_____

Limited to Medical Profession in U. S. A.

ditional sum you advance, you still save money.

The larger three-year premium may, if you choose, be paid in three annual installments. A 5 per cent carrying charge is added for this, but the three-year policy still cuts your insurance cost.

If you buy your theft insurance in a mutual, dividend-paying company, you save even more money. The mutual company, since it has no stockholders, divides excess earnings among its policyholders. But look for one with a fairly consistent record of dividend payments and with a non-assessable contract.

How much can you save by following these suggestions? Let's apply the plan to a household with this make-up:

Woman's diamond ring	$ 275
Man's watch, semi-precious earrings, gold wedding band, sterling silver cigarette lighter, and all other jewelry items belonging to the family	200
All other property likely to be stolen, including the family's clothing, linens, clocks, lamps, tableware (not sterling), luggage, radio, typewriter, golf clubs, cameras, and fishing equipment	$1,000
An additional 20 per cent to cover damage to premises and property during theft or attempt at theft	200
Cash on hand and usually carried by members of household	100
Securities on hand	100

Even though the total of all values listed above comes to $1,875, a policy of $1,500 might be written under the "blanket" form that protects any and all property. At the rates for a typical large city—*e.g.*, Chicago—a policy of this blanket type will cost $48.13 a year. It includes $1,000 of "theft-away-from-the-premises" insurances. But let us see what results we get by following the previously described recommendations for buying theft insurance:

First, we fit the policy to the

[PLEASE TURN TO PAGE 156]

specific make-up of your property. We insure the $275 diamond ring specifically, cover the smaller, miscellaneous jewelry items with $200 of insurance, and the balance of property with $1,400 of insurance—a total of $1,875. We add an additional $1,000 of "theft away from the premises" which is enough to cover the remaining property.

This policy protects your household fully. Yet its annual premium is only $39.71 as opposed to the $48.13 of the 100 per cent blanket policy. This is a cut of over 17 per cent in cost even before applying our other recommendations.

TIPS SLICE COSTS

The other suggestions direct that the policy be written in a mutual, dividend-paying company for a period of three years. With a dividend rate of 15 per cent, your net outlay for the three years thus becomes $84.38. This amounts to $28.13 a year instead of $48.13—a reduction of over 40 per cent in your theft insurance cost.

SAVE BY SWITCHING

What if you now hold a policy written for one year? You can have it rewritten for three years in the same company and get the benefit of the lower rate. But if you have to switch from a non-dividend-paying policy to one in a dividend-paying company, it is better to wait until the policy comes up for renewal.

Should you cancel your present policy, the company would compute the premium for any time elapsed according to a short-rate table. This would raise your past premium and might wipe out any savings from dividends under the new policy.

Here is one additional check on theft insurance costs: Rates for the residence theft policy have recently been increased in varying degrees. Because of these raises, you *may* find it more economical to insure your property under a different policy, the personal property floater. This insures against almost every possible loss, including the kinds covered under regular fire and theft policies.

FOLLOW THESE POINTERS

To summarize:

¶ Have your residence theft policy written to the specifications of your property.

¶ Include ample "theft-away-from-the-premises" insurance.

¶ Buy your theft contract for a period of three years.

¶ Pay the entire premium in advance, or pay in three annual installments.

¶ Buy your insurance in a mutual, dividend-paying company.

—PHILIP GORDIS

petrolatum a prompt covering dressing...effective against potential infection and burn pain.

'VASELINE' PETROLEUM JELLY
is the world's leading brand of
PETROLATUM U.S.P.

Nature heals the burn. But medical science, through the bitter experience of war and civilian disaster, has now developed a new treatment for creating optimal healing conditions.

Together with plasma and internal chemotherapy, petrolatum . . . known widely as 'Vaseline' Petroleum Jelly . . is important in this new care of burns, as a covering dressing against invasive bacteria . . . soothing . . . non-irritating to cells. Effective against burn pain . . . covering exposed sensory nerve endings.

In a study of 5,609 minor industrial burns[1], when 84 different methods of burn treatment were used, it was found that burns treated with simple petrolatum healed in an average shorter time, and required average fewer dressings, than did burns treated with all other preparations observed.

'Vaseline' Petroleum Jelly, for covering burn surface wounds and for impregnating gauze dressings, is available at drug stores everywhere...in tubes and jars. 'Vaseline' Borated Petroleum Jelly in tubes only.

1. J.A.M.A. 122:909 (July 31) 1943

Vaseline
REG. U.S. PAT. OFF.
PETROLEUM JELLY

MADE ONLY BY CHESEBROUGH MFG. COMPANY, CONS'D, NEW YORK, N.Y.

Group Practice

(*Continued from page* 100)

interest but can substitute for another. In a small organization, versatility is imperative. As the unit enlarges, specialists can be added or developed. We contemplate adding another physician soon.

Thousands of M.D.'s have the nucleus of a fine group such as ours. Yet they labor long hours by themselves. By attracting young physicians of good character and training, they could extend their influence. They could gain time for extra-professional pursuits. They could provide better care for more patients and add to the economic security of their families.

To insure a group's success, here are some essentials I learned the hard way: Income division should assure subordinates a fair livelihood, provide protection for the original investor, and allow funds for expansion. Free time should be dealt out in proportion to length of service. An opportunity should be provided to develop along special lines. Congeniality is a prerequisite.

—ANONYMOUS

Anecdotes

¶ MEDICAL ECONOMICS will pay $5-$10 for an acceptable description of the most exciting, amusing, amazing, or embarrassing incident that has occurred in your practice. Address Medical Economics, Rutherford, N.J.

OBRON

FOR THE OB PATIENT

CALCIUM

PHOSPHORUS

IRON

8 VITAMINS

all in one capsule

*Dicalcium Phosphate Anhydrous	768 mg.
Ferrous Sulfate, U.S.P.	64.8 mg.
Vitamin A (Fish-Liver Oil)	5,000 U.S.P. Units
Vitamin D (Irradiated Ergosterol)	400 U.S.P. Units
Vitamin B_1 (Thiamine Hydrochloride)	2 mg.
Vitamin B_2 (Riboflavin)	2 mg.
Vitamin B_6 (Pyridoxine Hydrochloride)	0.5 mg.
Vitamin C	37.5 mg.
Nicotinamide	20.0 mg.
Calcium Pantothenate	3.0 mg.

*Equivalent to 13 gr. Dicalcium Phosphate Dihydrated

Specifically Designed for the OB Patient

DURING PREGNANCY

OBron—in a single capsule—supplies calcium, phosphorus, iron and 8 vitamins in sufficient amounts to meet the increased needs of both mother and rapidly-growing fetus.

DURING LACTATION

OBron conveniently helps to meet the increased nutritional demands engendered by the accelerated glandular activity and the loss of large amounts of nutrients in the milk.

a ROERIG *preparation*

J. B. ROERIG AND COMPANY • 536 Lake Shore Drive • Chicago 11, Illinois

CALLING MISS BREDOW!

Your office trouble-shooter offers tips on cleaning medical equipment

Q. I am a medical secretary who often finds herself cleaning instruments, apparatus, and treatment rooms. Can you tell me how to do these chores properly and efficiently?

A. If you have assisted the doctor in an examination or treatment, you should first dispose of all waste matter. Then if the instruments used have been in contact with infected matter, place them in a disinfectant solution, such as 5 per cent lysol or 3 per cent phenol, and leave them for half an hour. Designate a special place, perhaps behind a screen, where used instruments and soiled glassware can be cleaned or where they can be kept until you are able to attend to them.

Scrub the instruments with soap and hot water, rinse them in clear hot water and then in ether or alcohol. Next dry them thoroughly. If the instruments were used in an infectious condition, boil them for ten minutes. Knives are the exception to this. They are dulled by boiling; a strong disinfectant is sufficient. If any of the instruments have hinges, use a few drops of oil to keep them functioning smoothly.

Syringes and needles may be kept in formaldehyde or ether. If blood was drawn through a syringe, clean the hub of the needle with a cotton swab. Unless the needle is made of stainless steel, it will rust. Guard against this by threading a fine steel wire through it.

SOAP AND SOAK

Wash glassware in warm water and soap. If matter has dried on it, you may have to soak it. After the washing, rinse with warm water and allow the glassware to dry by air.

The doctor's equipment represents a considerable investment and

---

► Questions from physicians and secretaries about business procedures in the medical office are answered here, as space permits, by Miriam Bredow. She is the author of "Handbook for the Medical Secretary" (McGraw-Hill) and Dean of Women, Eastern School for Physicians' Aides. In private life, she is Mrs. Heinrich Wolf, wife of a New York physiatrist.

---

should be given the best of care. Machines such as electrocardiographs, basal metabolism apparatus, diathermy units, and ultraviolet lamps will quickly deteriorate if not protected from dust. Dust, allowed to settle in the machines, will ruin them more quickly than actual use, so clean them daily to keep them in good condition. If the equipment is used infrequently, protect it with pliofilm covers.

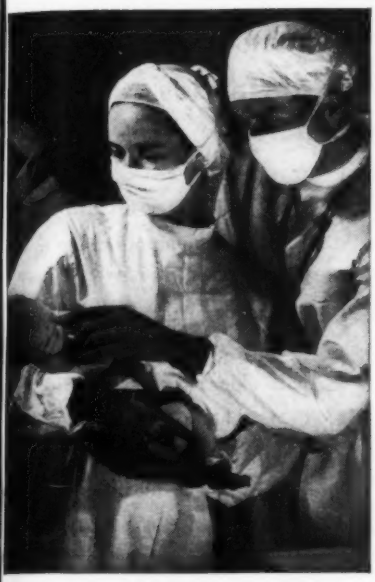
Clean, gleaming equipment is a good medical assistant's pride. Use metal polish on metal parts and give wooden cabinets an occasional polishing with furniture oil. Keep a soft dust cloth handy to run over a machine before and after it is used.

Examination and treatment rooms must, of course, be spotless. A few minutes of your time before and after each patient is all that is needed. Remove all soiled linen and used instruments. Pick up any hairpins that may have been dropped and wipe away powder or other substance that has been spilled.

The doctor will expect you to supervise the housekeeping of his office, waiting room, and treatment rooms. While the heavy cleaning will be done by porters and charwomen, it is up to you to see that the curtains are washed whenever necessary, that rugs and draperies are cleaned, and that plants and flowers are kept fresh. Be sure that light bulbs are replaced and torn magazines discarded.

—MIRIAM BREDOW

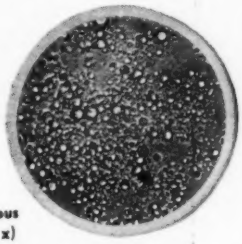
NOW—Over 1300 Hospital Nurseries Have Switched to JOHNSON'S BABY LOTION!



Cases of skin irritation decrease!

In hospital after hospital Johnson's Baby Lotion has proved so effective in cutting down cases of skin irritation that over 1300 hospital nurseries have adopted it for routine skin care!

And hospital after hospital reports that this smooth, white, antiseptic lotion—which is used exactly like baby oil—is bringing a dramatic reduction in the occurrence of urine irritation, heat rash, and other miliarias!



Lotion leaves discontinuous film. (600 x)

Lotion Leaves Discontinuous Film

The physical properties of new Johnson's Baby Lotion allow infant skin to function normally.

A homogenized emulsion of mineral oil and water, with lanolin and an antiseptic added, the Lotion leaves a discontinuous film as its water phase evaporates. (See photomicrograph.) This permits normal heat radiation; allows perspiration to escape readily; thus lessens danger of irritation.

JOHNSON'S BABY LOTION

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Please send me 12 free distribution samples of Johnson's Baby Lotion.

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Offer limited to medical profession in U.S.A.

The Newsvane

Cancer Control Program Gathers Momentum

Dormant until last year, the Government's cancer control program is finally beginning to roll. The National Cancer Institute will spend $5½ million during the current fiscal year on (1) grants-in-aid to state health agencies, (2) improving cancer teaching in medical schools, and (3) training selected medical men as cancer specialists.

These developments were summed up a month ago by Dr. Austin V. Diebert, chief of the Public Health Service's cancer control section. Speaking before the American College of Surgeons, he warned that "in spite of a highly developed educational program for laymen, the success of cancer control lies in the hands of professional groups."

Although "cancer is seen only four to five times yearly by the general practitioner," the PHS spokesman added, "there is great need to keep physicians alerted to recent developments in prevention, diagnosis and treatment."

A formula that evaluates the cancer problem in each state will be used in dividing up the grants-in-aid among state health agencies. Doctor Diebert reported that $2½ million will be spent on that phase of the control program this year. Another $1 million is ticketed for special projects conducted by medical centers, cancer clinics, and professional societies.

Medical schools will get a total of $1½ million for broadening their cancer courses and tieing them in with weekly cancer clinics. Postgraduate training is on the docket, too. At present, seventy-seven physicians are taking p.g. training designed to turn out cancer specialists.

Urges Hospital Staffs to Recruit Volunteers

To help alleviate their financial and public relations ailments, hospitals should put greater stress on volunteer workers. That's the view of Sister Loretto Bernard, administrator of New York's St. Vincent Hospital. But in making this point a month ago before the American College of Surgeons, she warned that plenty of staff cooperation was needed to maintain the supply of volunteers.

Active staff participation in recruiting volunteers and in training them is a must, according to Sister

Bernard: "The best source of supply of workers for your hospital will be loyal members of your staff, attracting their friends and acquaintances to the hospital." What made stepped-up recruitment essential, she reported, was the fact that the number of volunteers in metropolitan hospitals was down 80 per cent from the wartime figure.

One objection to volunteer workers, Sister Bernard noted, was the contention that they would "antagonize labor unions." To get around this, she recommended that hospital administrators "employ tact and sound judgment in assigning volunteers to work that does not conflict with the duties of paid personnel."

Foresees Poor Surgery in Next Generation

Teaching hospitals are responsible for the deplorable lack of surgical residencies which is causing so much turmoil among young ex-medical officers, asserts Dr. Harold L. Foss, chief surgeon, Geisinger Memorial Hospital, Danville, Pa. Their poor planning, he adds, will boomerang in the coming generation, when many hospitals will be forced to accept uncertified men for their staffs.

The disillusioned men, says Doctor Foss, have made it plain that they plan to engage in surgery, skilled or not. Some of them, he said, will "attempt any operation irrespective of its magnitude or technical difficulties." Eventually, he adds, their inadequate training "will be reflected in the surgical service rendered the people in the generation upon which we now enter."

Advocates Federal Loans for Medical Students

Federal subsidy of needy medical students might impair the quality of their work, believes Prof. Andrew C. Ivy, physiologist and vice president of the University of Illinois. Instead, he favors a Government loan system, because, as he recently told the American College of Surgeons, "the student would then realize that he was paying his way and the meritorious son or daughter of poor parents could obtain not only a pre-medical and medical education but also graduate training in medicine."

Professor Ivy recalled that he had taught medical students during both world wars, when their bills were paid by the Government. During those periods, he said, the scholarship level declined. "It is clear from my experience that work

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The unique B-D weave combined with Lastex* yarn controls the ACE *Reinforced* (No. 8) elastic bandage, permitting it to stretch just slightly more than twice its length . . . Laboratory tests have shown that this *controlled stretch* of an ACE *Reinforced* elastic bandage gives full support without inhibiting normal circulation.

The ACE *Reinforced* elastic bandage has *ALL* the advantages of rubber elastic bandages, PLUS *controlled stretch.* Lastex yarn is comparatively unaffected by perspiration, oil, grease and solvents that may shorten the life and reduce the therapeutic value of rubber reinforced bandages.

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RUTHERFORD, N. J.

in medicine is superior when the student or his parents pay the bill. A B grade is good enough for Uncle Sam but not for parents."

Death Rate Seen at All-Time Low

The U.S. mortality rate will probably reach an all-time low in 1947, the Metropolitan Life Insurance Co. reports after a study of statistics of the first six months of the year. The death rate for that period, 7.6 per 1,000 policyholders, was 3.8 per cent lower than that of the same period in 1946.

Deaths from pneumonia and influenza were 13 per cent under the previous all-time low of 1945, says the company, while tuberculosis mortality dropped 8 per cent below the 1945 rate, 20 per cent below the 1942 rate, and 35 per cent below the 1937 rate. The syphilis rate has declined 30 per cent in ten years.

Other declines from the 1946 rate included diabetes mellitus, 6 per cent; cardiovascular-renal diseases, 1.2 per cent; homicides, 12 per cent; suicides, 7 per cent; and accident deaths, 13 per cent.

Graduates Get Five-Year Support as Teachers

A new grants-in-aid program designed to alleviate the shortage of teachers and research workers in medical schools has been announced by the John and Mary R.

Outstanding Members of a Distinguished Family

NEO-SYNEPHRINE HYDROCHLORIDE... time-honored nasal decongestant—famous for over a decade of distinguished performance in relieving the upper respiratory symptoms of colds, sinusitis and allergic rhinitis. Supplied as ¼% and 1% in isotonic saline, ¼% in isotonic solution of three chlorides (Ringer's) with aromatics, ½% in water-soluble jelly.

NEO-SYNEPHRINE SULFATHIAZOLATE... a true chemical compound in clear solution 0.6%... provides the decongestive effect of ¼% Neo-Synephrine plus ample bacteriostatic action, with a minimal concentration of sulfathiazole... clears the nasal airways for greater breathing comfort... tends to limit the spread of infection caused by secondary invaders.

NEO-SYNEPHRINE WITH PENICILLIN... vasoconstrictor and antibacterial for use in acute and chronic sinusitis. Supplied as a combination package—when mixed each cc. contains at least 1000 units of penicillin in ¼% Neo-Synephrine Hydrochloride. Special buffer holds the pH of the mixed solution at 6.0... enhances the stability of penicillin in solution, helps restore normal acidity of nasal mucous membranes.

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Markle Foundation, which will distribute $250,000 in 1948-49 and a probable total of $1,250,000 over five years. Participating schools will nominate their most promising graduates for five-year "post-fellowship" grants that will enable them to remain as faculty members or researchers.

Would Attempt U.S. Sickness Index

The need for a national index of sickness and injury is all too evident, says Theodore D. Woolsey of the Public Health Service; for no statistics are now available that can be applied with any degree of reliability. "Previous surveys," he adds, "have been used to make national estimates, but these estimates have, perforce, been accepted on good faith. They may be good, but we have no way of knowing."

Dozens of valuable scientific papers have been based, for example, on the National Health Survey of 1935-1936, says Mr. Woolsey. Yet that survey was made before the evolution of modern sampling methods and may not have been completely dependable.

Mr. Woolsey believes it would be possible to institute a continuing survey of households, which, through the use of tested sampling procedures, would produce what he calls "calibration statistics." He cites the value of the British Health Index, which has provided monthly morbidity statistics since 1943.

[PLEASE TURN TO PAGE 172]

Behind the Label...

In the ultra-modern Bayer Laboratories at Trenton, N. J., aspirin is made with infinite care, and under the most exacting scientific controls. In all, seventy different tests and inspections are employed to insure the quality, uniformity, purity and fast disintegration for which Bayer Aspirin tablets are famous. And behind these controls are 46 years of experience in making this best-known of all analgesics.

BAYER
ASPIRIN

The analgesic for home use

He believes its cost has been justified. "New relationships between morbidity and social factors are being discovered. Some of these are relationships about which we already know a good deal for certain communities in the United States, but the Health Index provides statistics from which statements about the population as a whole can be made."

Most M.D. Deaths Due to Heart, Brain Diseases

Doctors, on the average, live just about as long as their nonprofessional brethren. At age 25, life expectancy is 43.54 years for male physicians and 43.31 for the adult, white, male population. This parity holds through all ages.

The annual death rate of physicians—20.5 per thousand—is also close to the general rate, 20.2. But there the resemblance ends, for physicians have higher death rates from the degenerative diseases—particularly the cardiovascular-renal diseases—and much lower ones from most of the infectious diseases and surgical conditions.

These are some of the conclusions drawn by Louis I. Dublin, Ph.D., and Mortimer Spiegelman of the Metropolitan Life Insurance Co., from a statistical study of AMA records covering active and retired physicians, and deaths among them, in the period 1938 through 1942.

Viewing the relatively low mortality rates from infectious diseases among physicians, the Metropolitan statisticians surmise that doctors, utilizing their special knowledge, early recognize the hazards that affect their health. They point out, on the other hand, that since present-day understanding of the degenerative diseases is limited, the doctor has no special advantage in preventing or correcting them.

Diseases of the heart and coronary arteries cause 40.7 per cent of all doctors' deaths; intracranial lesions of vascular origin account for 10.8 per cent; cancer causes 9.7 per cent; nephritis, 5.9 per cent; pneumonia and influenza, 5.5 per cent; arteriosclerosis, 2.4 per cent; diabetes mellitus, 2.2 per cent; tuberculosis, 1.6 per cent; cirrhosis of the liver, 1.3. Other

WALKER

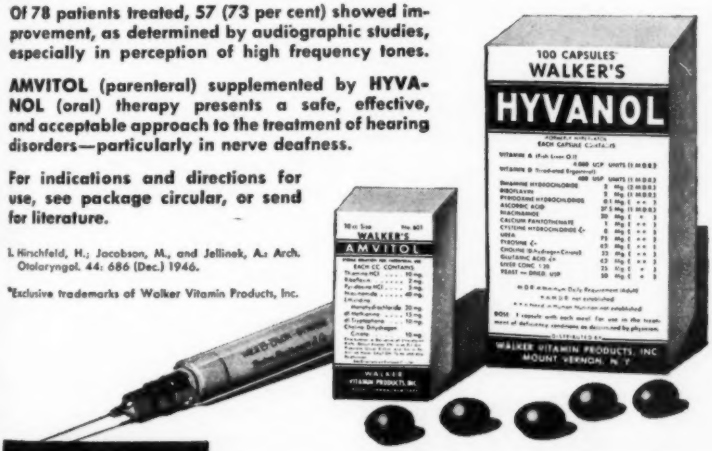
AMINO ACID-VITAMIN THERAPY in HEARING DISORDERS

Clinical improvement in acuity of hearing has been demonstrated in a high percentage of patients treated with amino acids and vitamins in combination as presented in AMVITOL* and HYVANOL.*[1]

Of 78 patients treated, 57 (73 per cent) showed improvement, as determined by audiographic studies, especially in perception of high frequency tones.

AMVITOL (parenteral) supplemented by HYVANOL (oral) therapy presents a safe, effective, and acceptable approach to the treatment of hearing disorders—particularly in nerve deafness.

For indications and directions for use, see package circular, or send for literature.



1. Hirschfeld, H.; Jacobson, M., and Jellinek, A.: Arch. Otolaryngol. 44: 686 (Dec.) 1946.

*Exclusive trademarks of Walker Vitamin Products, Inc.

Walker VITAMIN PRODUCTS, INC., MOUNT VERNON, N. Y.

diseases rank below 1 per cent each. Accidents cause 4.6 of all deaths among physicians; suicides, 1.9 per cent. The statisticians also found that for every 100 deaths among 100,000 white, adult males, there were the following deaths among 100,000 physicians:

Leukemia and aleukemias	175
Biliary calculi and other diseases of the gallbladder	145
Intracranial lesions of vascular origin	120
Diseases of the heart and coronary arteries	118
Arteriosclerosis	116
Cirrhosis of the liver	111
Pneumonia and influenza	109
Diabetes mellitus	108
Suicide	104
Automobile accidents	89
Cancer	81
Appendicitis	77
Hernia and intestinal obstruction	75
Nephritis	73
Ulcer of the stomach or duodenum	62
Accidents other than automobile	60
Diseases of the prostate	54
Tuberculosis	45
Syphilis	34

Wants Specialists to Act as G.P. 'Subs'

Specialists should help out the overworked general practitioner by putting themselves on call now and then for emergency work, says a G.P., Dr. Martin D. Kushner, of

RIASOL Leads the Parade in PSORIASIS

More and more physicians and their grateful patients are learning that RIASOL is definitely a leader in the field of psoriasis. It has earned its reputation on the basis of the superior results it has produced in an oftentimes baffling disease.

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- **RIASOL is simple, convenient and pleasant to use.**

RIASOL contains 0.45% mercury chemically combined with soaps, 0.5% phenol and 0.75% cresol in a washable, non-staining, odorless vehicle.

Apply daily after a mild soap bath and thorough drying. A thin, invisible, economical film suffices. No bandages necessary. After a week, adjust to patient's progress.

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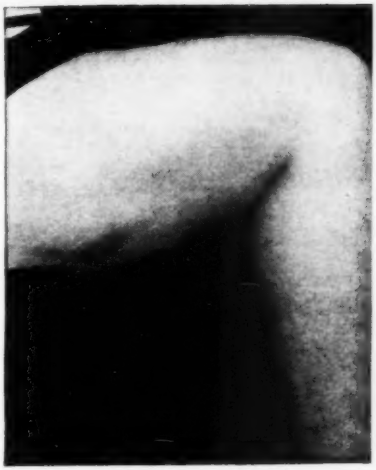

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. . . a distinctive antiseptic nasal decongestant

NARAKON* Solution with Desoxyephedrine has been proved by clinical tests to be safe and effective in achieving nasal antisepsis and decongestion in the therapy of simple inflammatory and allergic rhinologic diseases. • The potent germicidal and tissue-penetrating qualities of **NARAKON** Solution stem from its content of benzalkonium chloride, to destroy common secondary pathogenic invaders of

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nasal membranes in record time...without causing tissue injury or ciliary paralysis. A small but effective amount (1%) of *dl*-Desoxyephedrine Hydrochloride aids in promoting mucosal decongestion with virtual freedom from rebound turgescence and systemic action. • Also available as ***NARAKON*** Plain (without vasoconstrictor) for administration over extended periods as necessary. • ***NARAKON*** Solution (Plain or with Desoxyephedrine) is an aromatized, isotonic, aqueous solution, buffered to a suitable pH. It may be administered by atomizer spray, with dropper, as nasal douche, or tamponage. • ***NARAKON*** Nasal Solution is the first of a distinctive new series of meritorious medicinal agents to be introduced to the professions under the hallmark of "*Baybank*".

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BAYBANK*

TRADE MARK

Philadelphia. "Specialists are often left with time on their hands after their short and regular office hours," he recently told his county medical society.

"There is no doubt that most of this time is consumed in furthering the progress of medical science. I believe, however, that a great many specialists still have sufficient time and would be willing to do occasional emergency work among the suffering public."

He suggested that the society prepare lists of men who would be willing to accept emergency calls. "This would be a most welcome gesture, appreciated by the public. It surely would endear the specialist to the general practitioner."

PHS Offers Research Grants to M.D.'s

Physicians planning to do research in medicine or the related sciences are invited to apply for U.S. Public Health Service Research Fellowships. The stipend is $3,000 a year for those without dependents and $3,600 for those with dependents. An increase of $300 a year is granted to reappointed fellows, but except in unusual cases a post-doctorate fellowship is limited to two years. Special research grants are also made to applicants who have demonstrated outstanding ability in a special field, the stipend being fitted to the individual case.

Inquiries may be addressed to the Division of Research Grants and Fellowships, National Institute of Health, Bethesda 14, Md.

Medical Bureaus Make Mark in West

A chain of medical economics bureaus is now operating on the West Coast, sparked by Rollen W. Waterson, executive secretary of the Alameda County Medical Association. The first of these bureaus got its start in Alameda County in 1945. Others were opened in San Francisco and in San Jose early this year. Still others are being organized in the Bay Area.

Each bureau is sponsored by a different county medical society but all the bureaus in the chain are united under the control of a single

New Dependability...
New Rapidity of Action

in the control of

SCABIES and PEDICULOSIS

Quickly Lethal for

The Sarcoptes scabiei of scabies

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Kwell Ointment establishes a new high in therapeutic efficacy in the treatment of scabies and pediculosis. Its action is rapid, dependable, and positive. Pleasant to use, it produces no troublesome or disabling skin reaction or dermatitis. One application usually suffices for complete eradication; a second application is usually not required. Kwell Ointment contains 1% of the gamma isomer of 1,2,3,4,5,6-hexachlorocyclohexane in a vanishing cream base. At all pharmacies. Samples and literature to physicians on request.

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board of directors. Representatives of each participating county society sit on the board. While largely autonomous in their day-to-day operation, the local bureaus engage in joint purchasing, some centralized bookkeeping, joint printing, and a constant interchange of ideas and experience.

The bureaus offer a wide range of services. Collections are an important one. In the last two years, bureau employes have interviewed more than 100,000 patients with overdue accounts and have learned virtually every reason that can be advanced for delinquency and dissatisfaction. For the less than 1 per cent who cannot pay their bills in full, it recommends adjustment; physicians are invariably willing to comply. A much larger group are dissatisfied with the amounts of bills because they do not understand the factors underlying them. To these people, bureau representatives explain tactfully just why the doctor charged what he did; a large proportion of delinquents accept the explanation gracefully and pay their bills. More important, says Mr. Waterson, many of them lose any resentment they may have felt toward the physician.

The bureaus' office-management "package" includes bookkeeping, auditing, billing, cost analysis, and individual counseling in patient relationships. It costs from $25 a month up. In addition, the bureau arranges the financing of accounts receivable through banks; works with the fee-complaint committees

the aged

the overworked

the convalescent

the neurasthenic

the chronically fatigued

the constitutionally delicate

These are the patients . . . *for whom*

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is the ideal tonic

to restore appetite,

vigor and general tone.

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Eskay's Neuro Phosphates *is universally prescribed because . . .*

it is therapeutically effective . . .

it is exceptionally palatable . . .

it is easily tolerated . . .

of the societies; and maintains a credit reporting service.

More than 1,500 physicians are now using one or more of the bureaus' services, the vast majority employing them for collections. Support of the credit reporting service has been disappointing, says Mr. Waterson, with only a handful of doctors subscribing to it. "This," he comments, "checks with experience elsewhere. No one has yet found a way to get physicians to exchange credit information through a central bureau."

The three bureaus now in full operation have a total of twenty-six employes and an annual operating budget of about $100,000, which is considerably less than income.

Mental Patients Band for Mutual Help

Former patients of mental hospitals are now organizing mutual-assistance groups, similar to Alcoholics Anonymous, in various sections, following the success of the parent organization, WANA (We Are Not Alone), in New York City. Principal aim of the groups is to help discharged mental patients through the first weeks or months of their return to civilian activity. It assists them in finding employment or living quarters (if they have no families) and provides constant companionship for those who are inclined to be panicky. In one instance, a member could not summon enough courage to go to a physician's office for treatment until another member volunteered to go with him. According to Magazine Digest, the relapse rate of WANA members has been only 5 per cent, contrasted with a national average of 25 per cent.

Seeks Higher-Grade Negro Students

No new medical schools for Negroes should be built at the present time nor should the two existing ones be expanded, declares Dr. W. Montague Cobb, professor of anatomy, Howard University Medical School. The reason, he says, is that most of the students who would seek admission are not qualified to undertake medical training. Meharry Medical College and Howard had a total of about 2,600 applications this fall, but in the opinion of Doctor Cobb the candidates generally were of poor scholastic quality. "The professional aptitude ratings of applicants for our two schools," he says, "have regularly averaged below the national mean."

[PLEASE TURN TO PAGE 184]

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Doctor Cobb reveals that Northern medical schools created twenty-five openings for Negroes this year, but to no avail, since not a single qualified applicant appeared. He attributes the poor showing to a low grade of scholarship in Negro grade schools, high schools, and colleges, and says this condition must be corrected before Negro medical schools can expand.

Atomic Body Wants More Physicians in Field

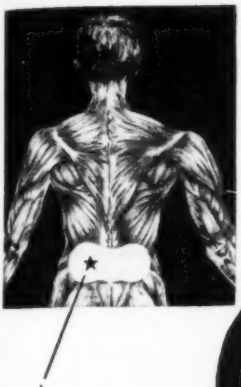
The country is in urgent need of more physicians and health physicists in the atomic energy field, the Atomic Energy Commission has informed Congress. Substantial aid, it says, should be given to universities training such specialists and to the trainees themselves. The commission also recommends similar training within the armed forces.

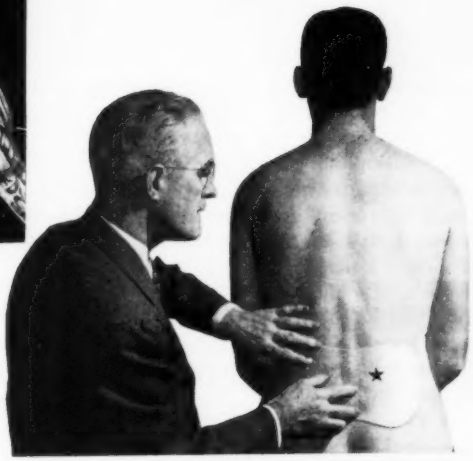
In the medical-program section of its semi-annual report, the commission summarizes some of the work that has been accomplished in the field to date:

1. *Detection and measurement of radiation hazards.* Example: Entirely new electronic instruments have been developed for detecting radiations of different penetrating power.

2. *Determination of biological effects of nuclear radiations on living tissue.* Example: Much knowledge has been gained of how tracer atoms may be used in cellular physiology and in studies of cancer.

3. *Detection and treatment of*





Here a Johnson's BACK PLASTER is being applied for low back strain.

Have you considered these advantages of Johnson's BACK PLASTER?

FROM the viewpoints of medical efficacy and practical convenience, these plasters merit your consideration for backache ailments.

Therapeutically, they do *three* jobs: They provide mild counter-irritation which induces local and reflex hyperemia—helping to relieve congestion and muscle pain. They provide warmth and protection in the painful area. They aid immobilization—give a strapping and supporting effect which tends to reduce pain and irritation.

They are practical for you and for the patient. They are safe and convenient. They give continuous slow treatment for several days. The Johnson & Johnson name is accepted by patients.

Johnson's BACK PLASTERS are particularly valuable for low back strain, sacroiliac arthritis, myositis, lumbosacral fascitis and intercostal neuralgia.

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Where the greater spasmolytic effect of belladonna is indicated, use the Johnson & Johnson BELLADONNA PLASTER with full belladonna strength.

Write for liberal free supply of Johnson's BACK PLASTERS and BELLADONNA PLASTERS. Both are helpful in many backache conditions. Johnson & Johnson, New Brunswick, N. J.

Johnson's BACK PLASTER

acute and chronic radiation injury. Example: Techniques have been worked out for (a) detecting early radiation trauma and for (b) tracing accidentally ingested radioactive substances.

4. *Setting of human tolerance standards and methods of protection.* Examples: (a) Large-scale animal experimentation has produced data useful in estimating the human body's total daily tolerance of nuclear radiation. (b) Tolerance dosages of radioactive substances dispersed in air, water, or on surfaces have been established. (c) Industrial masks have been developed.

5. *Decontamination.* Example: Improved methods have been devised for disposal of fission products and for decontamination of operating facilities.

One year after fission by-products had been made available to medical science, physicists and doctors were able to reveal some of the tentative steps they had made in utilizing radioactive substances:

At Bethesda, Md., Public Health Service scientists had tagged *Salmonella typhimurium* with a radioactive isotope and were trying to discover how it strikes in the cellular structure and how antibodies react against it.

The PHS had found that radiosulphur can be incorporated in penicillin if it is introduced into the mold that produces *Penicillium notatum.* The service hopes that experimentation with tracer-penicillin will indicate how the biological works and how it combats certain infections.

Researchers at Memorial Hospital (N.Y.) have incorporated isotopes in hormones and nucleic acids and hope to develop a method of localized radiation in some tissues.

At the Barnard Free Skin and Cancer Hospital, St. Louis, the synthetic cancer-producing substance, methylcholanthrene, has been tagged with radioactive Carbon 14, making it theoretically possible to determine how the substance produces cancer in laboratory animals.

At Vanderbilt University School of Medicine, Nashville, Tenn., radioactive manganese and gold are being used in treatment of leukemia, lymphoma, and Hodgkin's

UTRITION—vouched for by top nutritionists

ANTON J. CARLSON, Ph. D., M. D., world's foremost authority on nutrition, says in his Foreword to the Revised Edition of the booklet entitled "Legislation Which Renders It More Difficult to Secure Adequate Nutrition":

"The facts at hand today eliminate all questions as to the nutritive value of vitamin A fortified margarine[1] as compared to butter . . ."

THE COUNCIL ON FOODS AND NUTRITION of the American Medical Association, in a report published in the Journal of the American Medical Association, Sept. 16, 1944, says:

"When margarine is fortified with vitamin A[1] the investigations that have been made lead to the conclusion that it can be substituted for butter in the ordinary diet without any nutritional disadvantages."

[1] Nucoa, the first margarine to add Vitamin A, guarantees 15,000 U.S.P. units in every pound, winter and summer. This is 6,000 units above the minimum for fortified margarine as established by Federal Standard of Identity.

LAVOR—vouched for by millions who enjoy it

1941

1946

Typical of the satisfaction that Nucoa, America's most popular margarine, gives is the enjoyment of Nucoa in the home of the children pictured at left. Nucoa has been the Madeira family's chosen spread for bread for about twenty years. Says Mrs. Madeira:

"Our use of Nucoa, begun for economy, has been continued for pleasure. We like Nucoa's dependably fresh flavor and nourishing goodness, and the fact that it contains a guaranteed amount of Vitamin A, winter and summer. My children's good growth, and their alertness and success in school and play, give me confidence that our diet, including Nucoa all these years, has been well selected."

Why not try Nucoa in *your* home? It will give you confidence, we believe, in encouraging wider use of margarine—for enjoyment as well as good nutrition.

utritious NUCOA

WITH 15,000 U.S.P. UNITS OF VITAMIN A

Disease. At Tulane University School of Medicine, New Orleans, radioactive sodium has been used experimentally to determine the cause of edema in congestive heart failure. And at the Cedars of Lebanon Hospital, Los Angeles, radiophosphorus is being used in studies of coronary occlusion.

Says Residencies Skimp Essential Training

One-year residencies are not realistically planned for the man who intends to go into small-town practice, declares Dr. D. C. Badger, a pediatrician of Hobbs, N.M. In his case, he says, only a third of his residency was spent in general service, but he now has to devote 70 per cent of his time to it.

During his training in general service, he says, all respiratory infections except pneumonia were referred to otology. The result was, he got no experience in their treatment. Similarly, all skin conditions were referred to dermatology. Yet now the nearest dermatologist to him is 250 miles away.

Doctor Badger bases part of his criticism on a tabulation of all the cases he handled in 9¾ years of pediatric practice in a town of 15,000, during which time he had a total of 3,520 patients. He was prompted to make the study, he writes in the Rocky Mountain Medical Journal, by the discovery that he had had only two cases of diabetes in four years of practice, al-

though he had spent one-third of a one-year residency on diabetics and nephritics alone.

The doctor believes that residencies should be replanned on the basis of the quantitative expectancy of diseases in private practice.

Claims Thought Waves Can Span Ocean

A British psychologist, Prof. John Hettinger of London University, says he has gathered statistical evidence supporting the "probable existence" of telepathic power capable of spanning the Atlantic. In a report to the British Association for the Advancement of Science, Professor Hettinger describes a series of tests he made with "controls" in New York and "sensitives" in London, neither group having been apprised of what the psychologist was attempting.

While a New York control studied a picture of Joe Louis in action, the London sensitive reported: "Two men in the attitude of boxing." A New York picture of a waiter holding a tray with two small glasses evoked the London response: "I am holding a small, round tray with two glasses on it." And when, in New York, a control looked at a picture of a doctor examining a war prisoner's mouth, the London sensitive said: "Something is wrong with the mouth. I rather get the impression of a dentist."

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Total nitrogen	7 %	
Amino acid and polypeptide nitrogen	3.6%	
Carbohydrate		37 Gm.
Fat		2 Gm.
Ash		9 Gm.
Calcium	1.2%	
Phosphorus	1 %	
Sodium	0.35%	
Moisture		2 Gm.
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